An Interpretative Phenomenological Analysis on the experience of parenting and being parented for mothers diagnosed with Borderline Personality Disorder

by

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ACADEMIC DOSSIER

LITERATURE REVIEW: “Staff attitudes towards the borderline personality disorder diagnosis: A literature review.”

PROFESSIONAL ISSUES ESSAY: “What distinctive contribution can the profession of clinical psychology make in today’s NHS? In what ways should the profession be concentrating its efforts in the future?”

PROBLEM-BASED LEARNING REFLECTIVE ACCOUNT: “The relationship to change”.


PERSONAL AND PROFESSIONAL LEARNING DISCUSSION GROUP (PPLDG) PROCESS ACCOUNT SUMMARY 1

PERSONAL AND PROFESSIONAL LEARNING DISCUSSION GROUP (PPLDG) PROCESS ACCOUNT 2 SUMMARY 2
STAFF ATTITUDES TOWARDS THE BORDERLINE PERSONALITY DISORDER DIAGNOSIS: A LITERATURE REVIEW.

LITERATURE REVIEW

DECEMBER 2010

YEAR I
ABSTRACT

This paper reports on the literature published on staff attitudes towards the borderline personality disorder (BPD) diagnosis over time, and research on training programmes to address attitudes towards this client group. Following a computerised literature search, ten articles were identified on staff attitudes towards BPD, with four identified on training programmes to address such attitudes. Review of the literature revealed a focus on nurses’ attitudes, with relatively consistent negative staff attitudes found towards BPD. Findings suggested this was generally due to lack of understanding of the client group, with staff indicating a need for more training/education. Training programmes produced promising results in improving staff attitudes towards BPD, but these improvements were not well-maintained over time. Future research should focus on what makes this client group more challenging than others, and also the perspectives of other mental health professionals. Further research is also required on the long-term effectiveness of training programmes on BPD.
DECLARATION OF POSITION

My interest in staff attitudes towards individuals with a diagnosis of BPD developed from previous environments I had worked in: an inpatient unit for women with BPD, and a specialist personality disorder service.

In both settings I was surrounded by staff who facilitated my understanding and empathy towards this client group, but who also orientated me to the wider, derogatory attitude of professionals towards individuals who held the label "borderline personality disorder". My role as a facilitator in a series of focus groups with this client group also exposed me to the clients’ experience of these negative, discriminatory attitudes from mental health professionals. This increased my curiosity on whether attitudes are hopefully changing, or if training/education can facilitate attitude change.

INTRODUCTION

The “Personality Disorder” Diagnosis

Borderline personality disorder (BPD), a sub-type of personality disorder, is located within the axis II section of the DSM-IV. Its diagnosis is defined by a “pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood” (APA, 1994).

Due to the very nature of personality—generally a set of stable characteristics—those with a diagnosis of personality disorder were deemed untreatable by mental health services. Staff attitudes to the personality disorder label were first illustrated in a study on psychiatrists’ attitudes by Lewis & Appleby (1988). Psychiatrists rated vignettes involving a person with a personality disorder diagnosis (compared to depression or no diagnosis) as not mentally ill, in control of their behaviour, and that these individuals would be wasting their time.
The National Institute of Mental Health in England (NIMHE, 2003) challenged this perception with their innovative paper: “Personality disorder: no longer a diagnosis of exclusion”. The paper identified the need for mental health services to begin providing care for this population. Subsequently, in 2009 the National Institute for Health and Clinical Excellence (NICE) published guidelines on BPD, outlining the standards that should be met when working with individuals with this diagnosis.

NICE (2009) reports the frequency of all personality disorder subtypes is in excess of 50% in mental health settings, with BPD being the most prevalent category of personality disorder presenting to services. Due to their high presentation to services it seems feasible to assume that most mental health professionals will encounter an individual with a BPD diagnosis at some point in their career.

To explore the function of staff attitudes towards BPD, theories of attitude shall be outlined and referred to in relation to the research evidence. Furthermore, due to developments on how to treat and manage clients with this diagnosis (e.g. NIMHE, 2003; NICE, 2009) it is anticipated that attitudes towards the diagnosis may have improved over time due to increased knowledge. Hence it seems sensible to present the literature in a chronological order to assess for such changes. Following the presentation of literature on staff attitudes, several studies on changing staff attitudes towards BPD will be discussed, to assess whether interventions can challenge staffs’ perception of the BPD diagnosis.

**Attitude Theories**

Katz (1960) identified four attitude functions: firstly, the adaptive function, which indicates the function of an attitude, is to achieve goals or avoid adverse outcomes. Another function is the knowledge function; which allows an individual to
make sense of the world, i.e. the development of stereotypes. The third- known as the value-expressive function- explains attitudes as a way of expressing the individual’s values, central to their self-concept. The final function is the ego-defensive function; hypothesizing that attitudes are utilised to protect the individual from psychologically damaging information/events.

A well-known theory linked to attitudes is the cognitive dissonance theory (Festinger, 1957), which explores conflicting attitudes and/or behaviours. Festinger (1957) argues that conflicting attitudes and/or behaviours bring about a cognitive disharmony; therefore one of the cognitions/behaviours must be changed or adapted. This allows the cognition to fit with other cognitions/behaviours, which restores cognitive consistency.

**METHODOLOGY**

Key terms were searched in combination in PsychInfo, Medline, and Embase in order to generate relevant literature. Search terms used were “personality disorder”, “BPD”, and “borderline personality disorder”, in combination with “staff attitudes”, “nurse attitudes”, “psychiatrist attitudes”, “psychologist attitudes”, “nursing staff attitudes”, “therapist attitudes”, and “clinician attitudes”. These searches generated up to 453 articles, which were screened for dissertation abstracts, non-English language papers, duplicate papers, and irrelevant papers.

“Borderline personality disorder” and “attitudes” were then searched with “training” in the same databases, which generated 49 articles. Using the aforementioned screening criteria this was reduced to 4 relevant articles.

Inclusion criteria were applied to include articles investigating attitude concepts towards service users with a diagnosis of BPD only. Articles investigating BPD and co-morbid diagnoses were excluded. The sample required the inclusion of
staff from the mental health profession. Articles on training required changing attitudes towards the BPD diagnosis, or characteristics/behaviours associated with the BPD diagnosis, e.g. self-harm.

A total of 10 articles were found for staff attitudes towards individuals with a diagnosis of BPD, with only 4 articles found on training/education to address staff attitudes towards BPD.

LITERATURE REVIEW

Staff Attitudes towards Borderline Personality Disorder

In 1993 a study by Fraser & Gallop assessed both nurse attitudes and behaviours towards individuals with BPD, compared to those with schizophrenia or affective disorder (AD). Using the Staff Response sub-scale from Colson’s Hospital Treatment Rating Scale, authors assessed for positive and negative feelings towards each of these client groups. An analysis of variance revealed significantly higher negative feelings and significantly lower positive feelings rated for the BPD diagnosis, compared to AD and schizophrenia. Using a standardised observation scale (Heineken’s Confirmation/Disconfirmation Rating Instrument) on 17 nurses facilitating inpatient groups (with authors blind to diagnoses in the group), an analysis of variance revealed significant differences between responses to different diagnostic groups. Those with the BPD diagnosis received significantly less empathic responses from the facilitator compared to those with AD, or those from the “other” category (diagnoses other than BPD, AD, and schizophrenia). The responses individuals with a BPD diagnosis were more likely to receive were “impervious” and “indifferent” (p< .001), compared to individuals with AD. There was no significant difference reported in the responses received for those with a BPD diagnosis and those with a schizophrenia diagnosis.
The study provides a useful insight into attitudes, as well as behaviours, towards different client groups. Some positive design points were the employment of a “blind” observer, and the use of well-validated tools to assess attitudes and behaviour. Unfortunately the small sample size employed means the generalisability of the findings is questionable, but the study could provide a useful template for successive studies to replicate. A major critique is the lack of information provided on the results. While significant differences were reported between diagnostic groups, there were no descriptive statistics to ascertain whether differences occurred between BPD and schizophrenia, but did not reach statistical significance due to insufficient sample sizes.

Nehls (2000) approached the issue of staff attitudes towards BPD using a qualitative method. Seventeen case managers of individuals with a diagnosis of BPD were interviewed on their experiences in this role. Two major themes emerged: monitoring concern and monitoring boundaries. Case managers of individuals with a BPD diagnosis felt they had to deliberate over how much concern was felt due to the frequent expression of crises and risk, particularly suicidality. This led to conflicting feelings around concern for the client, and lingering thoughts about whether this concern was unnecessary. Monitoring boundaries also presented conflicting feelings for clinicians; as a caring professional they felt developing a therapeutic relationship was an integral part of their role, but were wary of their relationships with individuals with BPD. One clinician felt they had different boundaries for individuals with BPD because they’re “too difficult”, and their fear of an “intense relationship”. For a qualitative study, the sample size of seventeen was reasonable, but still inadequate to generate any generalisable findings. The employment of a group of
analysts working from a particular framework, however, reduced the subjectivity of
the analysis—often an issue in qualitative studies.

Two years later Cleary, Siegfried & Walter (2002) surveyed a large sample of
Australian mental health professionals (229, 67% nurses), on knowledge of, and
attitudes towards, BPD. Eighty per cent disclosed they found this client group
moderately or very difficult to manage, with 84% stating clients with BPD were
more difficult to manage than other client groups. Optimistically, the staff surveyed
were keen to improve their skills, with 95% agreeing to spend two hours a month on
training/education on BPD.

While the study provided a useful insight into the views of an impressive sample of
various mental health professionals, its major limitation of the study was the
questionnaire employed. There were no validity or reliability tests to aid the
development of the questionnaire, which queries the usefulness of the findings
presented.

A year later a study looking at nurses' perceptions and attributions for
challenging behaviour was published (Markham & Trower, 2003). The authors
assessed staff attitudes by comparing BPD, schizophrenia, and depression; ten years
after Fraser & Gallop (1993) compared the same diagnostic groups. Fifty inpatient
nurses completed a modified version of the Attribution Style Questionnaire.
Scenarios were used to assess attribution based on: internality, stability, globality,
controllability of the cause and/or negative event. Participants also rated their
sympathy, optimism for change, and personal experience of working with each
diagnostic group (all factors were rated on a 7-point scale). Staff rated their
experience of working with this client group as significantly more negative than
working with people with depression or schizophrenia. Interestingly, experience of
working with BPD was not correlated with any of the attribution dimensions, although stability and controllability were rated as significantly higher for BPD compared to schizophrenia and depression. Staff were also least optimistic about, and expressed significantly less sympathy towards, those with BPD, compared with depression and schizophrenia.

Markham (2003) also surveyed the same group of nurses, and an additional 21 healthcare assistants (HCA’s), on the Social Distance scale and the Beliefs about Dangerousness questionnaire (both assessed for validity and reliability). Comparing BPD and schizophrenia, nurses rated that they kept more social distance from those with BPD, and saw them as more dangerous than individuals with a diagnosis of schizophrenia. The HCA’s, remarkably, made no such distinction with scores equivalent between diagnoses. This raises the issue of whether education/training improves negative attitudes towards the BPD diagnosis. HCA’s held fewer prejudices than nurses towards BPD, despite presumably having less training in mental health.

In terms of the conduction of the research, the questioning of the same staff for each diagnostic condition was beneficial in controlling for individual differences and requiring a smaller sample size; however, it raises a serious issue of demand characteristics from the staff. Completing a questionnaire on three types of diagnosis is likely to make those completing the survey aware of what the researchers are investigating, and may have led nurses to score according to what they understood the aim of the study to be.

In 2006, a study by Deans & Meocevic assessed 47 inpatient nurses’ attitudes towards the BPD diagnosis. The authors assessed attitudes of clinical description where nurses reported that individuals with BPD were manipulative (89%), and 38%
labelling them as nuisances. They also looked at emotional responses; 32% reported that clients with BPD made them feel angry. Questions on the management of BPD revealed participants largely agreed that individuals with BPD were responsible for their own actions, e.g. breaking the law (79%) and suicide (64%). Furthermore, only 44% reported they knew how to care for individuals with BPD, with just over one quarter of the sample agreeing that those with BPD should be managed by specialist services. This study reveals very similar attitudes to those found in the original Lewis & Appleby (1988) study. In addition, it appeared staff self-perceptions of unpreparedness when working with this diagnosis may result in staffs' desire to pass this client group on to other services.

While this study was positive in its identification of nurse attitudes towards BPD in description, emotion, and management, its limited sample of nurses and lack of comparison group suggests generalisability is minimal. Without comparisons to other diagnoses, an alternative explanation of the findings could be that the sample held negative attitudes to service users in general, as opposed to being aimed specifically at those with the "BPD" label.

One year on Forsyth (2007) published a study on inpatient staff attitudes towards BPD, compared with attitudes towards major depressive disorder (MDD). Twenty-six inpatient staff (nurses and healthcare assistants) were given vignettes and a selection of questions from an empathy scale (Burns & Nolen-Hoeksema, 1992) measuring anger, empathy, and helping behaviours for MDD and BPD. In line with Deans & Meocevic (2006) anger towards BPD was higher than anger towards MDD, although not significantly. Empathy was lower in vignettes with a BPD case than the empathy reported for MDD, but was not significantly lower. There was, however, a significant difference in diagnostic group for helping behaviours; staff were
significantly more likely to rate they would help those with MDD, compared to BPD. In contrast to Markham & Trower (2003), the authors did not detect a significant difference in attitudes towards BPD and MDD, but found differences when questions were regarding behaviours, similar to behavioural responses found by Fraser & Gallop (1993).

While this seems to suggest some contrary evidence to an earlier study, the sample size of 26 suggests the differences between diagnostic groups may not have been found due to the inadequate sample size. A positive design aspect was the use of vignettes. While it limits the ecological validity of the study, vignettes allowed for a more valid measure of attitudes towards the BPD label rather than attitudes towards the individuals with BPD staff have worked with.

Five years after the Cleary et al. (2002) study in Australia, James & Cowman (2007) replicated the study in Ireland with 65 nurses from inpatient and community settings. James & Cowman conducted a pilot study initially to modify the original questionnaire, by assessing for face validity, content validity, and consultation with professionals. Using the modified questionnaire the authors found 75% of respondents perceived those with BPD as moderately or very difficult to look after, with 80% reporting they were more difficult to look after than other client groups. Both responses showed a decrease of approximately 5% from the Cleary et al. (2002) study, indicating improved attitudes over time. A high percentage (90%) indicated they would partake in training on the BPD client group if it were available.

From this study it seems there is a promising decrease in negative perceptions of BPD among staff, with a large proportion wanting to improve knowledge and management of this diagnosis. Unfortunately, due to ethnocentricity in both studies it may be differences in mental health services and/or attitudes between countries,
rather than between two time points. Furthermore, Cleary et al. used mental health professionals, whereas James & Cowman surveyed nurses, indicating the findings could also be a reflection of professional differences.

Following a series of quantitative reports, a qualitative study in 2008 by Woollastion & Hixenbaugh, explored the experiences of 6 inpatient nurses working with individuals with BPD. Analyses revealed a core theme from the interviews; identifying those with BPD as “destructive whirlwinds” on the ward. Four major themes were also generated, with the first focusing on care-giving. Staff felt they were unable to help individuals with this diagnosis, leading to the belief that individuals with BPD cannot get better. Staff reported feeling inadequate, and wanted to be “the one” to make individuals from this client group better. Theme two centralised on “splitting”- a behaviour often attributed to individuals with BPD. This resulted in staff feeling either idealised or demonised, and splitting of attitudes/opinions among staff members. Another label attributed to individuals with this diagnosis- manipulation- was the focus of theme three. Staff felt wary of interactions with this client group and often advised one another to document interactions to avoid exchanges later being “used against them”. The final theme looked at the threats of harmful behaviours- towards self, others, or property- if needs were not met. These threats often led to staff discomfort due to their responsibility of individuals on the ward.

This study provides some useful information on what behaviours exhibited by clients with the BPD diagnosis are fuelling the negative attitudes felt by staff. Interestingly, the study shows the desire within staff to be able to help this client group, and that negative attitudes are not only from interactions with this client group, but also stem from a feeling of failure and inadequacy. The sample size and
limited population studied, unfortunately, seems to identify the study as an exploration of experiences of nurses on a particular unit, rather than real insight into the experiences of staff working with BPD in general. Also the use of a ward staff member as an analyst of the data indicates their own experiences and perceptions were likely to influence the analysis—an issue common among qualitative studies.

In 2009, another research team replicated the Cleary et al. (2002) study, with a Greek population of mental health professionals (Giannouli, Perogamvros, Berk, Svigos, & Vaslamatzis, 2009). The majority of the sample felt that individuals with the BPD diagnosis were moderately or very difficult to manage (85.5%)—a higher proportion than both of the previous studies (80% and 75%). Surprisingly, their perception of individuals from this client group as more difficult than other diagnostic groups was considerably lower than the previous studies (65% versus 80% and 84%). Staff indicated the inadequate management of BPD was largely due to poor education (51%), with 95.6% indicating they would devote two hours per month for training seminars on this client group.

In contrast to studies in Ireland and Australia it seems there are a higher proportion of professionals in Greece who do not seem to view those from this client group as more difficult than other client groups. Unfortunately it still cannot be ascertained whether this difference was due to changes over time or variations in culture. Nonetheless the findings suggest there is some hope that those with the BPD diagnosis may be treated as equivalent to clients from other diagnostic groups in some services. Overlap between the three samples is evident by their emphasis on the need for further education on this diagnosis, in line with qualitative studies revealing issues in staffs' ability to effectively work with BPD.
In 2009, Ma, Shih, Hsiao, et al., used a qualitative approach to explore care by fifteen inpatient nurses in Taiwan. Five themes emerged from the data which resulted in the development of an inpatient care pathway for individuals from this client group (Appendix A, figure 1). “Shifting from honeymoon to chaos” was a theme representing the journey of working with individuals with BPD, whereby relationships were positive initially, but changed to chaotic over time. Care outcomes seemed to be influenced by three main factors: nurses’ expectations for positive or negative outcomes, routine versus individualised care for individuals with BPD, and adequate versus inadequate support from peers.

While the care pathway is an interesting and visual representation of the process of working with this client group, it cannot be easily applied to other countries due to issues of ethnocentricity. The process could, however, be replicated in other countries to produce a visual learning tool for staff. This could illustrate how various factors impact on experience of working with this client group, including factors external to the client, i.e. peer support, expectations from staff. As with all qualitative methodology there is also the issue of subjectivity when analysing data. Encouragingly, several strategies were employed to ensure trustworthiness and rigour, including reflexive diaries, consultation with an expert, and re-analysis of the data two weeks after the initial analysis.

Staff Training on Borderline Personality Disorder

While it is evident from the research literature that the majority of participants felt that education was vital in addressing negative staff attitudes, and improving staff-client relationships, there are only a handful of articles which address whether education actually does have an impact.
The earliest identified study on staff training to change attitudes towards BPD was by Krawitz (2001), who reported on a training programme delivered to mental health clinicians in Australia. The workshop covered theory, statistics and practical skills for working with this client group. The questionnaire completed before and after the workshop required attendees to rate willingness, optimism, enthusiasm, confidence, theoretical knowledge, and clinical skills on a five-point scale. Each rating had significantly improved following the workshop \((p = .05)\). From the original sample of 910, 418 were available to complete a six-month follow-up questionnaire (Krawitz, 2004). A series of t-tests revealed the improvements following the workshop were maintained, or showed a non-significant decrease.

The research by Krawitz (2001, 2004) provides an innovative addition to the research available on staff attitudes towards BPD, by providing a potential solution to the negative attitudes found in staff. In addition the study maintained a healthy sample size, with different mental health professionals from a range of settings, making its generalisability to staff in mental health services viable. Unfortunately, the studies also had some limitations; a large issue being the questionnaire. The factors used had not been tested for reliability or validity; hence, it is unconfirmed whether the factors rated are true measures of attitude. Additionally, there was no control group employed to ascertain staff attitudes over time in a sample who did not receive training.

Four years later another study was published (Commons Treloar & Lewis, 2008), exploring attitudes to self-harm in BPD. A two-hour lecture was presented to 99 emergency medicine clinicians and mental health clinicians, covering information on BPD, self-harm and suicide in BPD, exemplary case studies, and clinical guidelines. To assess for attitude change individuals were asked to complete the
Attitudes towards Deliberate Self-Harm Questionnaire (ADSHQ) before and after the lecture. Analyses revealed that both staff groups showed a significant improvement in attitudes towards self-harm following the lecture, with a medium effect size. Encouragingly, there were equivalent effects across different professions (nursing, allied health, and medical), suggesting the program was relevant to a range of staff groups. Regrettably, male attendees, and staff who were trained in a hospital setting with over 16 years of experience, did not experience a significant attitude change.

Following on from the previous study, Commons Treloar (2009) explored whether the theoretical approach used in the education programme impacted on staff attitudes towards self-harm in BPD, immediately after the workshop and six months later. Approaches used were Dialectical Behaviour Therapy – an approach designed specifically for BPD - and a psychoanalytic approach. Each approach was used to explain self-harming behaviours in a series of case studies. Both approaches resulted in a significant improvement in ADSHQ scores, again, with medium effect sizes. At six-month follow-up, however, the improvement was only evident in the group who had attended the psychoanalytic programme, and the effect size had lowered to a small effect.

This study provides valuable information on how different theoretical orientations can impact on staff attitudes and understanding of self-harm in BPD. While it provides an innovative contribution to research on staff attitudes towards BPD, it is limited by its focus on self-harming in BPD, rather than the label of BPD itself.

Both studies improved upon the research by Krawitz by employing a standardised measure to assess attitude change. Unfortunately, it is difficult to know whether the attitude change is towards self-harm, or self-harm within the BPD
population. Similarly to Krawitz (2001, 2004) control groups were not employed in either study, which does not address the possibility of attitude changes occurring over time without a training intervention.

DISCUSSION

Disappointingly, there appears to be no consistent change over time for attitudes towards clients with BPD, with most studies finding staff viewed individuals with BPD in a negative manner, found them more difficult than other client groups, and felt incompetent in their ability to work with them.

The studies found comprised a good mix of qualitative and quantitative research, which allowed for information on general attitudes towards BPD, but also the individual experience of working with this client group, and the impact this has on staff. While it does not justify the negative attitudes found in quantitative studies, qualitative studies explained how some of the day-to-day difficulties experienced when working with this client group can accumulate into pejorative opinions found in staff surveys.

Linking attitude theories to research on attitudes towards BPD, it seems the theories of attitude explain the research relatively well. The functions described by Katz (1960) appear to explain the negative attitudes expressed as protective, as working with BPD seems to lead to feelings of incompetence and failure. According to the ego-defensive function, assigning blame to the client protects the person’s self-perception of being a “caring professional”, and prevents the psychologically damaging idea that they may be incompetent in their job.

The cognitive dissonance theory (Festinger, 1957) also explains the feeling of failure and incompetence when working with this client group. This is illustrated well by the Nehls (2002) study. Staff reported conflict over whether to be concerned
about individuals with BPD, due to repeated threats of self-harm/suicide. Their lack of emotion conflicts with pre-existing cognitions that the person is a “caring professional”, and is capable of fulfilling this role. Due to the conflicting cognitions the person may change the feeling of failure to one of blame, labelling the client as “difficult”.

Applying the knowledge function (Katz, 1960), the behaviours exhibited by some individuals with BPD, e.g. threats of harm, results in staff stereotyping individuals with the BPD diagnosis. This knowledge function enables staff to predict future behaviours from individuals with BPD and prepare for them.

Study Limitations

There did appear to be some improvements in attitude based on the Cleary et al. (2002) study, and subsequent replications (James & Cowman, 2007; Giannouli et al., 2009). Due to ethnocentricity, however, it is unclear whether changes are due to cultural differences in attitudes, or improvements in attitudes over time. Unfortunately the lack of a validated questionnaire in the original study, and the 2009 replication, queries the validity of the results found in these two studies. Most studies used a validated questionnaire, and tested questionnaires for reliability, each study had their own idea of which factors they felt assessed attitudes (e.g. empathy, dangerousness), which resulted in an interesting range of studies. Regrettably this also made cross-study comparisons, and the ability to ascertain attitude change over time, impossible.

An issue applicable to some studies was the lack of participant-blind methodologies, whereby the aims of the study were fairly obvious from the questionnaires, e.g. diagnostic comparisons. This evidences the potential of demand characteristics or social desirability in the studies, whereby staff were likely to be
aware of the aims of the study and may have answered in a biased manner. This may explain inconsistencies on attitudes towards BPD in comparison to other diagnoses.

Studies have generally focused on nurses, which doesn’t account for other important professions. Clinical psychologists seem to be minimally represented in the studies, despite their role in providing psychological therapies to this client group. Psychiatrists and social workers have also been under-represented, despite their pertinent role in sectioning. It is, therefore, important to assess for any prejudice and/or discrimination in these professional groups towards BPD, which may result in their exclusion from inpatient units.

**Future Research**

Future research would also benefit from further qualitative exploration on what aspects of this client group staff find difficult to work with, to facilitate greater understanding of what differentiates this client group from others. Future research would also benefit from incorporating a diverse sample of professionals to improve upon the application of study findings to real-world settings.

While comparisons of BPD to other diagnostic groups has allowed for greater understanding of the stigma around the BPD label, it does not ascertain whether the negative attitudes are towards the “personality disorder” label or the “BPD” label. The focus on BPD was due to their high presentation to mental health services, but it would be useful to acknowledge whether clinicians discriminate against other types of personality disorder based on their experience of, and attitudes towards, BPD. Future research also needs to focus on developing training programmes which produce long-lasting changes in attitudes towards BPD, and address the groups who did not achieve significant attitude change in the Commons Treloar & Lewis (2008)
study. Qualitative information could provide important material for features/characteristics training programmes need to address.

**Clinical Implications**

The negative attitudes expressed raise the possibility of a potential attitude-behaviour link in staff. Staffs' negative perceptions of this client group are inevitably going to influence their interactions with individuals with the BPD diagnosis, hence having a dire effect on the service these individuals receive. This is exemplified in the Nehls (2000) interviews, where case managers stated they modified their behaviours when working with this client group, compared to working with individuals with other diagnoses, e.g. schizophrenia. Furthermore, assessment of nurses' behaviours while facilitating an inpatient group (Fraser & Gallop, 1993) revealed less empathic responses towards inpatients with a BPD diagnosis compared to AD. The indication that staff behaviours are suggestive of the negative attitudes staff hold is likely to leave individuals with a BPD diagnosis feeling stigmatised and discriminated against.

From Krawitz's (2001) study it seems there are educational interventions which can improve staff attitudes to BPD, however, some of the factors improved upon begin to decrease over time (Krawitz, 2004). From Commons Treloar & Lewis (2008) and Commons Treloar (2009) there was also evidence of improved attitudes towards self-harm in BPD. The maintenance of attitude change following psychoanalytic approach indicated potential for the long-term effects on attitude change using this approach. Its clinical significance, however, was small at follow-up, indicating follow-up training needs to take place in order for long-standing improvements to occur. Findings from Giannouli et al. (2009) found that the
majority of staff would be willing to devote 1-2 hours per month to seminars on BPD, which could potentially be used for regular training on BPD.

Reflections

While I do not agree with the largely negative attitudes held by staff towards this client group, exploring qualitative studies on some of the staff experiences with people with this diagnosis I have become more sympathetic to the difficulties frontline staff may face on a daily basis with this client group.

Being involved in focus groups with this client group in the past I have been largely exposed to their negative experiences, without realisation of the distressing experiences the staff members also have. Reading the various studies in this area has helped me to develop a more holistic perspective on this issue, and more empathy for staff working with such a unique client group.

CONCLUSION

Unfortunately, from the literature there seems to remain a general negative attitude among staff when working with individuals with the personality disorder diagnosis. Only two studies found no significant difference between BPD and other diagnostic groups, and other studies indicated the majority of professionals rate this client group as more difficult than individuals with other diagnoses. In general the research is largely biased towards nurses’ attitudes towards BPD; hence it would be interesting to explore how other mental health professionals perceive this client group. Overall, it seems staff attitudes towards BPD, and self-harm in BPD, can benefit from training/education. Unfortunately, the number of studies in this area indicates a need for further research; particularly into long-term attitude change.
REFERENCES


APPENDICES

APPENDIX A. Different care outcomes for patients diagnosed with BPD in Taiwan
APPENDIX A.

Different care outcomes for patients diagnosed with BPD in Taiwan.
Figure 1 exemplifies the different care outcomes for individuals with a diagnosis of BPD in Taiwan (Ma, Shih, Hsiao, *et al.*, 2008).

Figure 1. Different care outcomes for patients with BPD in Taiwan: a two-stage care process.
WHAT DISTINCTIVE CONTRIBUTION CAN THE PROFESSION OF CLINICAL PSYCHOLOGY MAKE IN TODAY'S NHS?
IN WHAT WAYS SHOULD THE PROFESSION BE CONCENTRATING ITS EFFORTS IN THE FUTURE?

PROFESSIONAL ISSUES ESSAY

JANUARY 2012

YEAR II
INTRODUCTION

The National Health Service has undergone a number of recent changes, responding to the economic climate, but also in response to feedback from staff and service users. Some recent changes to the mental health services, and the role of the clinical psychologist, include the implementation of Improving Access to Psychological Therapies (IAPT), the New Ways of Working (NWW) for everyone (Care Services Improvement Partnership [CSIP] & NIMHE, 2007) publication and the “No Health without Mental Health” (Department of Health [DoH], 2011a) paper. An outline of these recent NHS changes will be presented, followed by a description and evaluation of the key areas a clinical psychologist, can continue to or work towards being involved in. This essay will focus on adult mental health, and the role of the clinical psychologist in relation to recent government developments which impact specifically on adult mental health services.

The first key area is related to the recent government implementations of IAPT and the responsible clinician role: clinical psychologists have the opportunity to move into leadership roles, as supervisors, service managers, or responsible clinicians. Alternatively, clinical psychologists in earlier stages of their careers can begin to develop their leadership skills by drawing on their formulation/treatment planning skills to offer consultation to individuals and/or teams.

Clinical psychologists’ key roles outside of the leadership framework will also be discussed. Their advanced therapy skills (employing formulation and a range of therapeutic models) and the development of IAPT services, allow clinical psychologists to focus their clinical work on individuals with complex mental health needs; specifically individuals with a personality disorder and individuals with schizophrenia (and other psychoses). Finally, future roles will be considered based
on the clinical psychologists' training to a doctoral level, which enables them to utilise and conduct research to inform clinical practice.

CHANGES TO MENTAL HEALTH SERVICES

New ways of working (NWW) for Everyone

NWW for Everyone is defined as the "development of new, enhanced and changed roles for mental health staff, and the redesigning of systems and processes to support staff to deliver effective, person centred care in a way that is personally, financially and organisationally sustainable" (CSIP & NIMHE, 2007, p.139). This programme was originally developed following a discussion among the psychiatry profession regarding the increasing demands and caseloads of psychiatrists, resulting in high levels of burnout (CSIP, NIMHE, Changing Workforce Programme, et al., 2005). The programme aims to focus on staff members' skills rather than their status within a team, moving away from the traditional team structure of the psychiatrist in charge of all cases. Following on from the NWW project the NHS Leadership Academy (2011) has published an NHS leadership framework which "sets out the standard for leadership to which all staff in health and care should aspire" (NHS Leadership Academy, 2011, p.6).

Recent publications indicate a major shift in the way NHS mental health services conceptualise leadership. Earlier models of service delivery appeared to emulate the earlier "behaviourist" theory of leadership (Bolden, Gosling, Marturano, & Dennison, 2003), emphasising the behaviours employed by an individual define them as a leader, e.g. the psychiatrist assigning diagnoses, determining treatment plans. The NWW paper suggests a shift to the innovative "dispersed" theory of leadership (Bolden et al., 2003), proposing that staff in all roles in an organisation can apply leadership influence over their colleagues and the service they work in.
The Future of Psychological Therapies

Following a report by economist Lord Layard, identifying mental health problems as significantly impacting on the country’s economy, the government developed a strategy of “Improving Access to Psychological Therapies (IAPT)”. The success of a pilot project led the government to release a four year plan (DoH, 2011b) to expand IAPT to a range of populations, i.e. older adults, children and adolescents, individuals from black and minority ethic (BME) groups, and physical health problems (DoH, 2011b). While this represents a potential threat to the clinical psychologists’ role as a therapist, it also presents a range of new roles for clinical psychologists.

IAPT and the latest government strategy “No Health Without Mental Health” (DoH, 2011a) has placed further emphasis on accessibility to psychological therapies as key to improving the mental health of the general public. With psychiatrists potentially moving away from a lead role in teams, and the government emphasising the crucial role of psychological therapies in future mental health services, it seems an appropriate time for clinical psychologists to move into a leadership role and ensure they demonstrate their unique abilities to guarantee a future in mental health services (Division of Clinical Psychology [DCP], 2007; DCP, 2010).

LEADERSHIP ROLES

Two recent government developments have provided significant potential role changes for clinical psychologists, now and in the future: improving access to psychological therapies, and the introduction of the approved clinician role.

Improving Access to Psychological Therapies (IAPT)

While the IAPT programme could be perceived as a threat to the “therapist” aspect of the role of the clinical psychologist, the BPS (2007b) has reframed this
programme as a positive prospect for the profession. Firstly, the development of new roles and new services provides the potential opportunity for more experienced clinical psychologists to work as supervisors of low intensity workers in IAPT services. The supervisory role of the clinical psychologist has already been evidenced in a number of Trusts who have introduced the graduate primary care worker role (DoH, 2003), leading to clinical psychologists moving into managerial roles, for example, with responsibility for the role development of the graduate primary care worker (DoH, 2003). Secondly, IAPT offers promising job opportunities for newly qualified clinical psychologists to work as high intensity workers, with job security, career progression to managerial roles, and further specialist training in cognitive behavioural therapy (CBT) (Clark & Turpin, 2008). However, IAPT is limited by the population it treats, focusing on common mental health problems, i.e. depression and anxiety; therefore there are a high number of individuals excluded from this service. Furthermore, it is limited in what it offers clients, i.e. CBT, although this is slowly changing (e.g. Gelman, McKay, & Marks, 2010).

This potential shift in job prospects indicates there would need to be changes to clinical psychology training programmes in the UK which, at present, requires the ability to utilise at least two evidence-based models of psychological therapy in clinical practice (Committee on Training in Clinical Psychology [CTCP], 2008). While the current accreditation criteria stipulates that one model must be CBT, this is not necessarily enough to be deemed “qualified” to work at a high intensity level, leading to suggestions that training courses in clinical psychology need to increase their courses’ emphasis on CBT competency (Moore & Amoako, 2010). An important point to consider, however, is the risk of clinical psychologists losing their
unique skill of drawing from a range of models; a skill other mental health professionals highly value in clinical psychologists (Cate, 2007). Although new models are being introduced this is likely to be a slow process and restricts clinical psychologists’ use of alternative models.

**The responsible clinician role**

Another recent development that allows clinical psychologists (and other mental health professionals) to move towards a dispersed leadership position is the introduction of the new Mental Health Act 2007. Recent changes have allowed other professionals, including clinical psychologists, to fulfil the responsible clinician role; an approved clinician who has been given overall responsibility for a service users’ care (originally reserved for medical professionals). Allowing other professionals to be appointed as a responsible clinician offers the opportunity for the most qualified person, in terms of the service users’ needs, to lead on their care plan (Merchant, 2007). With the IAPT programme and the government paper “No Health without Mental Health” emphasising the importance of psychological therapies in treating mental health problems, it is evident that service users require greater input from clinical psychologists. It has been highlighted this method may be particularly valuable in community work (Merchant, 2007) where there is potentially less emphasis on pharmacological treatment. Professionals have responded with mixed views, with some favouring the opportunity for true multi-disciplinary work, and the opportunity to focus on professionals’ competencies rather than their job title (Merchant, 2007), in line with the dispersed leadership model. Controversially, psychiatrists stated other mental health professionals are less holistic than psychiatrists who can formulate within a biopsychosocial model (e.g. McQueen et
al., 2009): suggesting clinical psychologists need to illustrate this skills more explicitly to other professionals.

Gillmer & Taylor (2008) discuss responsible implementation of the responsible clinician role for clinical psychologists and highlight formulation as a key skill a clinical psychologist has to offer this role. Rather than drawing on diagnostic categories clinical psychologists can use their formulation skills to address particular conditions (e.g. developmental disorders, personality disorders) which do not respond to the traditional medical approach offered by psychiatrists. This responds to the request by NWW (CSIP & NIMHE, 2007) for care to become person-centred and competence-based, while also offering a leadership opportunity for clinical psychologists. A potential downfall of clinical psychologists adopting this role is the potential damage to the therapeutic relationship, if psychologists utilised their power to section individuals when working therapeutically with an individual.

CONSULTATION & FORMULATION SKILLS

The recent Good Practice Guidelines on the use of psychological formulation (DCP, 2011) has been developed to emphasise that formulation is a core competency for a clinical psychologist, which should draw on and integrate multiple factors, such as biological, social, and cultural factors. The document also raises the issue of diversity; by developing an individualised formulation for service users it can take into account cultural issues, which is not possible when receiving a psychiatric diagnosis. A key example is the diagnosis of schizophrenia, frequently criticised for being a culturally-bound diagnosis (Zandi et al., 2008), with some cultures perceiving hearing voices as a religious experience (Tanskanen et al., 2011). Developing a personalised formulation for a service user experiencing symptoms of
psychosis, or other culturally-bound diagnoses, can incorporate the religious and cultural beliefs of that individual.

Supporting the idea of a personalised approach, Lucock, Hall, & Noble (2006) surveyed psychotherapists and trainee clinical psychologists and found significant differences on the influence of client characteristics and psychological formulation in their therapists' practice, with trainee clinical psychologists placing a greater emphasis on these factors. This offers some evidence to the unique contribution the clinical psychology profession brings to treatment, formulating a treatment plan based on the clients' needs, rather than fitting their preferred treatment model to the client. From a service user perspective, one individual praised the importance of a psychologists' ability to be "very flexible about what type of approach to offer and use" (BPS, 2007a); an impossibility for therapists that are model-specific, e.g. cognitive behavioural therapists in IAPT.

Extending beyond direct clinical work, the formulation guideline (DCP, 2011) and NWW for applied psychologists (Onyett, 2007) stresses that clinical psychologists should offer training in formulation and formulation consultations within teams, supported by the published literature outlining the benefits to teams when formulation meetings are utilised (e.g. Summers, 2006; Berry et al., 2008). While formulations are commonly used by clinical psychologists in collaboration with service users, formulation meetings appear to remain unrecognised as part of a clinical psychologists' role in mental health teams (Cate, 2007) and provide a unique role for clinical psychologists to develop and occupy in the future. Furthermore, the use of consultation allows for clinical psychologists to become involved in implementing dispersed leadership; by sharing their skills with colleagues and increasing competence among mental health teams.
So far, qualitative research has explored clinical psychologists’ experiences of using formulation in multi-disciplinary teams (Christofides, Johnstone, & Musa, 2011). From the analysis the authors identified that clinical psychologists believe this is an efficient use of their time: they can provide a service to a larger number of service users by sharing formulation skills with professionals, compared to completing individual work with service users. In contrast, participants identified the difficulties of working in an “expert/supervisor” role, particularly when colleagues have a number of years of experience and/or are comfortable with their particular way of working. This issue is also raised by a newly qualified clinical psychologist who felt under-prepared in her role of offering consultations in formulation (Preedy, 2008). Clinical psychology accreditation criteria currently emphasises teaching on formulation, however, there is no reference to consultation skills (CTCP, 2008) despite newly qualified clinical psychologists often taking on consultations as part of their role (Preedy, 2008).

While this sounds like a potential niche the clinical psychology training programmes can focus on in the future, the key question is: do other professionals find consultation helpful? Summers (2006) interviewed staff who had been involved in formulation meetings led by a clinical psychologist, to identify their perceptions of these meetings. Staff identified the meetings as beneficial to care planning, staff-service user relationships, staff satisfaction and team-working, and encouraging of integrating different views and creative thinking. Despite the advantages, some traditional views emerged that formulation potentially made excuses for service users’ behaviours and read too deeply into behaviours, indicating the importance of clinical psychologists continuing to provide these consultations in order to gradually change these pessimistic views.
Berry, Barrowclough, & Wearden (2008) adopted a quantitative approach to assess staff perceptions of service users' mental health problems before and after formulation meetings, which summarised several therapeutic models into a diagrammatic personalised formulation. Results revealed there was a significant increase in the degree of control staff had over the service users' difficulties, reduced levels of blame, and higher levels of optimism regarding the service users' treatment. The meetings also led to staff feeling more confident in their work, suggesting this is in line with the NWW philosophy of encouraging competence at all staff levels, for greater person-centred care.

**ADVANCED THERAPY SKILLS**

The role of a clinical psychologist was traditionally to work as a therapist; however, applied psychology roles have evolved with increasing responsibilities, e.g., managing staff/service development, research/audit (BPS et al., 2005). However, statistics reveal that direct client work remains the core role of an applied psychologist (61.8%) (BPS et al., 2005).

Lake (2008) highlighted the unique skill of the clinical psychologist to "develop flexible and creative psychological interventions in an individual, group or organisational context" (Lake, 2008, p.13). He went on to describe the importance of these skills in settings where there are both complex client difficulties as well as complex service systems beyond the proficiency of IAPT. This is particularly pertinent for such diagnoses that have a high level of stigma attached to them and are frequently misused and applied to a wide spectrum of presentations. There is increasing evidence for psychological therapies for individuals with a diagnosis of schizophrenia, traditionally managed using pharmacological treatment. Additionally,
with the increasing evidence base in using psychological therapies to treat personality disorder, this should be a specialist role clinical psychologists fulfil.

**Personality Disorder**

Individuals with a diagnosis of personality disorder, particularly Borderline Personality Disorder (BPD), have often been perceived negatively by mental health professionals (Woollaston & Hixenbaugh, 2008); rejected by mental health services and labelled as “untreatable”. A series of publications (i.e. National Institute of Mental Health in England [NIMHE], 2003a; NIMHE, 2003b; National Institute of Health and Clinical Excellence [NICE], 2009), however, have aimed to challenge this and increase accessibility to services for individuals with this diagnosis. Publications highlight the importance of psychological approaches in working with this client group (NICE, 2009), as well as emphasising the capabilities required in staff teams working with this client group (NIMHE, 2003b), draw on the unique skills held by clinical psychologists. They describe as a necessity that staff can use formulation skills, a range of evidence-based models, evaluation of psychological interventions, and use of reflective practice. This description of key skills accentuates the potential role for clinical psychologists working in adult mental health, with each skill identified by the BPS as necessary to qualify as a clinical psychologist (CTCP, 2008). At present, service users with BPD have reported that treatment from psychiatrists often feels like a “trial and error” procedure (Rogers & Acton, in press) and psychological therapies are not generally offered to this client group by Community Mental Health Teams (CMHTs). Supporting this claim, an audit of compliance with NICE guidelines for BPD (2009) revealed only a quarter of service users with BPD received structured psychological treatment as recommended by NICE (Dunne & Rogers, 2011). To reduce the further neglect and exclusion of this
client group, clinical psychologists should have the necessary skills to lead on services for this client group to increase their access to psychological therapies.

Schizophrenia and other psychoses

Individuals with schizophrenia and other psychoses have long been treated using medical means, specifically anti-psychotics. However, recent NICE guidelines (2010) have indicated that psychological therapies, specifically CBT or family interventions, should be offered routinely to this client group. While this presents a role for clinical psychologists, in practice the recommendations surrounding psychological therapies are not being adhered to (Prytys, Garety, Jolley, Onwumere, & Craig, 2011). Authors found that 7-20% of eligible service users (across four CMHTs) with schizophrenia were offered CBT. Similarly, the percentage of suitable individuals offered family intervention work was 4-28%. When interviewed to explore why individuals were not offered the recommended psychological interventions, staff identified a range of reasons: firstly, their beliefs and understanding of psychosis illustrated an emphasis on the medical model and a belief that individuals with schizophrenia could not benefit from psychology due to the severity of their illness, or the effects were not sustained. Some professionals described using CBT skills, in line with NWW, in their interactions with individuals with psychosis, but emphasised this was limited due to the caseload/time pressures of working in a CMHT. While they acknowledged they could refer to the team psychologist, there was the significant issue of waiting list times in order to see the team psychologist. Ideally, with more individuals being seen by IAPT in the future, there will be a greater opportunity for care coordinators to refer service users with schizophrenia to clinical psychologists. Furthermore, there also appears to be a
potential for consultation work, to outline how individuals with schizophrenia can benefit from CBT/family work.

While there currently appears to be limited access to CBT for individuals with schizophrenia and other psychoses, it is important to consider the perspective of the service user: would they benefit from this alternative to medication if accessibility was addressed? Results so far are promising; with reviews of CBT for schizophrenia suggesting that CBT can produce large clinical effects on both positive and negative symptoms of schizophrenia (Rector & Beck, 2001). Furthermore, in cases where individuals do not benefit from medication alone, CBT can be a useful supplement (Rathod, Kingdon, Weiden, & Turkington, 2008).

Qualitative research has also emerged from Messari & Hallam (2003) who interviewed five individuals with psychosis who were engaged in CBT with a psychologist. The results were largely positive, with therapists positioned as reducing their distress, making the process educational and collaborative, and allowing them to explore alternative ways of viewing their experiences. Unfortunately their engagement with CBT was presented as a way of cooperating with professionals in order to be discharged from hospital, indicating service users’ motivation to engage fully with CBT may be questionable. Despite this potentially negative finding, the lack of motivation in some individuals with this diagnosis further emphasises the complexity of this client group and the necessity for clinical psychologists to work therapeutically with this client group, rather than protocol-driven therapists.

**RESEARCH SKILLS**

A final, yet crucial, key skill of the clinical psychologist is their use of research in clinical practice. The ability to critically appraise existing research as well as conducting research and contributing to the evidence base is identified as a
required objective to demonstrate competence as a clinical psychologist (CTCP, 2008).

This competence is a consequence of the Boulder conference in Colorado, 1949, when it was agreed that the most appropriate framework for applied psychologists was the scientist-practitioner model (Lane & Corrie, 2006). Working as a scientist-practitioner involves a clinical psychologist conducting research, and applying the results to clinical practice (Lane & Corrie, 2006). However, in the current economic climate, evidence suggests clinical psychologists are not prioritising the researcher aspect of their role.

A model of research activity

Holttum & Goble (2006) produced a comprehensive model that outlines the influences on the level of research activity a clinical psychologist completes, drawing on a range of models and papers applicable to research activity in the profession. This provides crucial information on the clinical psychologist as researcher, and highlights how changes can be made at various parts of the model to increase research activity. Several of the factors relate to personal characteristics a clinical psychologist possesses, including their attitudes towards research outcomes, their control beliefs related to their ability to conduct research and, tentatively, their sex role identity. The authors suggest that the high prevalence of females in clinical psychology may be, in part, related to the lack of continuation with research upon qualification. They argue that male-dominated professions, such as academic roles, are strongly linked to research, whereas female-dominated professions (including clinical psychology in the UK), usually fit within a caring role which does not place an emphasis on academic activities. This aspect of the model suggests changes at the selection for clinical training stage, both in terms of gender distribution of trainees,
and attitudes towards and competence in research. Using the Theory of Planned
Behaviour (Ajzen, 1991), the authors also proposed clinical psychologists develop
control beliefs regarding the external constraints of developing and conducting
research, e.g. lack of protected research time in role. Secondly, some clinical
psychologists held the beliefs that research activity was not a pertinent part of their
role, and did not fit with the professional identity of a clinical psychologist
(normative beliefs)- another issue that requires addressing at the training level.
Vocation-related issues suggest a need for clinical psychologists and service
managers to work towards dedicating a portion of a clinical psychologist’s time to
research activity. Finally, supervision/training in research was raised as an important
predictor of future research conduction, with the training institution and the
mentoring of doctoral research projects seen as important contributors to developing
practitioners interested in continuing research following qualification.

While clinical psychologists in the UK are trained to become scientist-
practitioners, a questionnaire study of a psychology department revealed just 57.5% of
the sample (n=40) were research active, with only 7.5% spending more than 10% of
their time engaging in research activity (Morton, Patel & Parker, 2008). Conversely, 65% of those surveyed reported they would like to spend more time
completing research activities. So why are clinical psychologists not conducting
more research? In support of the proposed model, suggestions offered by those
surveyed were generally related to a lack of time and/or resources, a lack of
opportunity, and in some cases, a preference for clinical work. Additionally, clinical
psychologists exhibited low self-efficacy in relation to their ability to conduct
research, indicating training courses need to focus further on research skills in
clinical practice. This factor was supported in a follow-up study by Wright &
Holtttum (2012) who, using the Holttum & Goble (2006) proposed model, identified that research self-efficacy is the strongest predictor of continued involvement in research activity following qualification.

The significance of the research supervisor during clinical training has also emerged from research as an important factor for successful publication of a doctoral thesis (Cooper & Turpin, 2007). Cooper & Turpin (2007) identified that only a quarter of trainee clinical psychologists’ theses’ were successfully published in a peer-reviewed journal. When identifying success factors, the most frequently identified factor was related to the supervisor involved, e.g. good relationship, motivated supervisor. Interestingly, determinants of failure to publish were related more strongly to trainee factors, e.g. lack of interest in research, and their new job, e.g. lack of time to write up thesis for publication. This study provides support for the Holttum & Goble (2006) model, as well as highlighting some necessary considerations for clinical training programmes: both in their selection of trainees and their selection of staff members, to ensure that research activity is not lost in future generations of clinical psychologists.

Evidence-based practice

In addition to the production of research, a key skill of a scientist-practitioner is to utilise research and protocols to inform clinical practice. Yet in practice Milne, Keegan, Paxton, & Seth (2000) identified that only 56% of clinical psychologists sampled drew on protocols and guidelines to inform their clinical practice, although the samples’ primary intention was to increase their use of protocols/guidelines in the following year. This presents a dilemma for the practicing clinical psychologist: working outside of an evidence base raises possible ethical issues that clinical psychologists are not offering service users the most effective treatment. However,
remaining within protocols/guidelines reduces the opportunity for clinical psychologists to draw from a number of theories and models (MAS, 1989) in order to work with complex mental health problems. This idea is encouraged by the DCP's (2010) leadership development framework, and is also raised by Addis, Wade, & Hatgis (1999) in their review of practitioner concerns in adhering to treatment protocols. The authors highlighted practitioner concerns that protocol-driven practice does not account for the service users' individual needs. Furthermore, the use of treatment protocol restricts the development of innovative treatments, a key role of the scientist-practitioner. This was further supported by a later paper by Spring (2007) arguing that evidence-based practice for clinical psychologists should not be reduced to guidelines/protocols. The paper emphasises the clinical psychologists' holistic view of evidence-based practice, drawing from the research evidence, from clinical experience (practice-based evidence), and equally important, the service user's treatment preference.

**MY REFLECTIONS**

*When considering which question to select from the list of essay titles I was initially tempted to “turn a blind eye” to the question highlighting how clinical psychologists can ensure a future in the NHS, in the current economic climate. Witnessing recent changes to the role of the clinical psychologists I was taken back to the introduction the programme director made prior to the interviews to obtain a place on the Surrey Clinical Psychology Doctoral programme. The talk was orientated around the changing role of the clinical psychology profession; moving away from therapy-based work into leadership and consultation roles. This was in stark contrast to my interests in working primarily in a therapist role. Despite entering my second year of clinical training I have maintained my position that*
therapy is still the most appealing and enjoyable aspect of my role as a trainee clinical psychologist, however, my commitment to clinical psychology has developed based on a professional identity that incorporates a variety of roles in clinical practice. From researching and writing this essay I have gained a greater understanding of how clinical psychologists have positioned themselves in light of the recent NHS changes, and feel more confident that we can maintain a unique and key role in mental health services.

CONCLUSION

NWW for Everyone has highlighted important changes are necessary to mental health teams to reduce the pressure on psychiatrists, and move towards a competence-focused work force, rather than profession-focused. With clinical psychologists currently salaried at a higher band than equivalent roles in other mental health professions, e.g. nursing, this leaves clinical psychology in a vulnerable position. At present clinical psychologists are valued by other professions for their ability to work with complexity, and consult to/supervise colleagues on complex cases (Cate, 2007). Furthermore, their skills in research are seen as valuable and unique to the clinical psychology profession: an important factor to be considered in light of research suggesting that psychologists are not utilising this skill (Morton, Patel & Parker, 2008).

With other mental health professionals training in therapy and the implementation of IAPT services, it is a critical time for clinical psychologists to demonstrate the breadth of their skills and ensure they maintain a lead role in these new developments, through supervisory or management roles, or a clinical role in new services, as high intensity workers. From consulting the literature it is apparent that clinical psychologists are starting to evidence their skills, particularly in
consultation and formulation, with supporting guidance from professional bodies (e.g. BPS) advising clinical psychologists in developing their roles in the changing NHS. However, training programmes need to revise their programmes to account for the changes to the clinical psychology role. A specific concern is the lack of interest in research within the profession: if clinical psychologists discontinue with this skill, there is a risk of losing their status as a scientist-practitioner which has both professional and ethical implications.
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PROBLEM-BASED LEARNING

REFLECTIVE ACCOUNT: THE RELATIONSHIP TO CHANGE.

PROBLEM BASED LEARNING

MARCH 2011

YEAR I
PROBLEM BASED LEARNING (PBL) TASK

In the initial PPDLG (personal and professional discussion learning group) meeting we were given the task of developing a presentation on “The relationship to change”, to present to our cohort and members of the course team. We were informed we had six weeks (six sessions) to plan the presentation.

THE GROUP PROCESS

When we were given the PBL task the initial thoughts from the group were around the abstract nature of the phrase given to us, and what the course team may be looking for from this task. We concluded it was related to the recent change we had undergone from starting the course, and the changes we expect our clients to make during therapeutic work. The initial sessions were spent discussing ideas of what we understood by the phrase; the relationship to change. I recall writing a reflective log throughout the period of time we spent planning the PBL presentation, and I was very aware of my difficulties contributing to the group. Reading back on my reflective log I felt a lot of frustration during our initial sessions, as it appeared some group members were repeatedly taking over the session discussing their perspective of “the relationship to change”, without giving others the opportunity to contribute. Although part of my frustration was the lack of awareness from my colleagues about “taking over”, I also felt a significant part of it was disappointment in myself for not ensuring my opinion was heard. Thinking back over my time in academia and employment I have always struggled to contribute to large group discussions, and have accepted a more passive role in response to others who are more outspoken. Reflecting on the early sessions in the group I think the combination of the ambiguous topic and my difficulties in contributing to large group discussions resulted in me taking on a more passive role initially than I would have liked. I hope
that in future group tasks I will ensure my opinion is voiced early on, both to increase my confidence, and to reduce the subsequent feeling of frustration and regret.

After several weeks of brainstorming we decided it was important to incorporate the various ideas group members had contributed, as well as what was currently relevant to us: our own relationships to change, our clients’ relationships to change, and the role of clinical psychologists in the NHS. On reflection I wonder whether our topics were actually just our assumptions of what the course team wanted us to cover, which helped reduce our anxiety, but potentially limited our creativity. We divided the presentation into six parts, and each group member had their own part of the presentation to develop. Retrospectively, this was probably detrimental to facilitating our development as a group; however, it was at this point I became more comfortable in my role in the group as I had a focus and specific task to complete. My experience of feeling part of the group came when I presented my part of the presentation to the group the following week. I received very positive feedback from the group members, and it was from this point I began to feel more able to contribute confidently to group discussions and voice my opinion.

My section of the presentation focused on considering the barriers to change based on a model developed by Burrowes & Needs (2009; see Appendix A, Figure 1). I considered the barriers to change model from my perspective as an adolescent; deciding whether I wanted to continue with college and education (academia was an important part of my identity). I then considered the model from “Leroy’s” perspective: “Leroy” was a case study we developed about an adolescent who was involved in a gang (an important part of his identity) and drug-dealing.
THE PRESENTATION

Presentations have always induced high levels of anxiety for me, despite my previous occupation exposing me to co-facilitator roles in numerous groups. I found great comfort in listening to the cohort share their anxieties about presentations, and I began to feel more relaxed as I realised I was presenting in a “safe space”. This process reminded me of the expectations we have of clients to reveal personal and sometimes embarrassing information, and the importance of the therapeutic relationship in reducing the anxiety clients might experience around disclosure in therapy.

The variation I noticed between our presentation and watching the others was the segregated structure of our group. Other groups were clearly more collaborative in their approach, and I now believe this was a sign of the group cohesion at the time of presentation. On reflection I believe we needed to spend more time together building relationships to feel more confident and comfortable with one another before we were able to collaborate on such an anxiety-provoking task.

REFLECTIONS FROM CLINICAL PRACTICE

Repeated cancellations

Reflecting on my clients’ relationships to change became an important factor to consider early on in my placement. I recall a particularly frustrating day during which I had several clients not show up to their appointments, without contacting me to cancel. At the time I felt irritable and disappointed that the clients failed to show up for appointments, without considering why. When I began to recall the content of my presentation, and consider the barriers my clients may encounter when they begin to consider change, I was able to appreciate the magnitude of the task for some clients. From comparing my experience with “Leroy’s” I realised I had much more
perceived control over my own ability to change, whereas individuals under mental health services may experience “learned helplessness” (Maier & Seligman, 1976). Due to the perceived lack of control over some mental health problems individuals may feel change beyond their capability or control.

The time I found reflecting on the PBL task most useful was during the process of writing this account. Following a client breaking a contract¹ I had set with her I had to discharge her from therapy. I found this the most frustrating and disappointing part of my placement so far, as I had felt we were building a good therapeutic relationship and making progress in her motivation and willingness to consider change. Prior to seeing this lady I was aware she had refused to engage in therapy, and only came to the initial appointment because the psychiatrist said he would not increase her medication unless she tried therapy first. Reflecting on the PBL task, and thinking about her relationship to change, I began to realise that while we had not made significant progress in targeting her OCD (obsessive compulsive disorder) symptoms, we had made some progress in facilitating her ability to contemplate change. Based on Prochaska and Diclemente’s “stages of change” model (1992; see appendix B, Figure 2), when I initially saw my client I perceived her to be in the pre-contemplation stage, as she was unable to acknowledge the impact her OCD symptoms were having on her life (despite rituals occupying the majority of her day). Before discharge she was able to openly discuss the negative impact these symptoms were having on her quality of life, and was beginning to contemplate change and the barriers she might face. Reflecting on this client in light of the PBL task allowed me to positively reframe the work we had done so far, and provided some positive reflections for me to present to the client at the discharge

¹ As my client regularly missed appointments we agreed a contract whereby she had to attend three sessions from every block of four.
session. This process provided an alternative perspective to assessing change in future clients I work with: specifically that I should not assess change based on my goals, but the goals of the clients.

The therapeutic relationship

From the first PPDLG session we were given this task to collaborate on, despite only knowing one another for a few weeks. From subsequent discussions the clear consensus was that, as a group, we would have appreciated time to build relationships in the group before collaborating on a task likely to evoke anxiety, i.e. a presentation. For me, this highlighted the importance of developing a therapeutic relationship with clients. Participating in a collaborative task with people I had known for a short period of time felt quite uncomfortable, and made me wonder about the anxiety and apprehension experienced by clients when coming to their assessment or therapy sessions. This allowed me to develop a more empathic response during my sessions with clients, when they struggled to disclose information, refused to engage in certain tasks, or did not show up to some sessions. By remembering my experience of the PBL task, and my difficulties in “finding my voice” among strangers, and sharing my personal experience of change, it has increased my patience and understanding and hopefully fostered better therapeutic relationships.

The importance of the therapeutic relationship has been studied extensively, particularly since Carl Rogers proposed that empathy, genuineness, and unconditional positive regard were both necessary and sufficient features of therapy (Rogers, 1957). By reflecting on my clients’ perspectives of entering therapy and contemplating change, both during the PBL task and on placement, and reflecting on
my own experiences of change it has hopefully built on these features and improved my ability to build relationships with clients.

The importance of the system

During my placement I have also began to consider the relationship to change with the individual's system in mind. From clinical practice I have realised that many clients initially agree to attend appointments and contemplate change due to encouragement or coercion from family, friends, or mental health professionals (as seen in my earlier clinical example). In my opinion, this raises a serious dilemma of whether it is ethical or efficacious to work with a client who is not in therapy out of choice.

Part of my placement involves working in a family clinic on an inpatient unit, which has further highlighted that a recent change in a system (e.g. a diagnosis of a mental health problem and/or an inpatient admission) is likely to impact on both the individual and people in their social network. Another ethical dilemma I have come across is not being able to reach families/carers that may want or need input from the clinic, but may not be able to access it as the individual who has been admitted does not give consent for us to contact their family/carers. At present we are encouraging ward staff to promote the clinic to families who come to the ward, to facilitate an alternative way for families/carers to learn about and access the clinic. Working within a systemic model has made me realise that during the PBL task we did give enough consideration to “the relationship to change” from the perspective of family members/carers. Furthermore, working within this model has now ensured I give greater consideration to the system during individual therapy.

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2 The clinic works with inpatients and their families/carers on the impact of the admission on relationships.
Exploring the importance of the system in change reminded me of the theory of reasoned action (developed by Azjen & Fishbein, 1980); one of the most established models of behaviour change (see Appendix C, Figure 3). The model suggests that when contemplating behaviour change we are influenced by "normative beliefs", reinforcing the idea that social support is important in behaviour change, reinforcing the importance of the systemic model. However, experience has taught me it can also be negative as social influence may lead to clients attempting to change behaviour before they are ready, which may result in high drop-out rates, a waste of resources, and a sense of failure.

I noticed this idea of "normative beliefs" influenced our PPDLG group, as a large influence on our presentation content revolved around what the course team expected from us and our presentation. On retrospect, I think if we hadn't been so focused on "normative beliefs" our content may have differed significantly. Some groups used role plays to illustrate points, which we discussed, but were concerned whether it was appropriate for the presentation and how it may be perceived by the course team.

Diversity

Working with the case study, "Leroy", during the PBL task facilitated some important pre-placement consideration of the importance of diversity when exploring the client's relationship to change. My placement base is in a very culturally diverse area, so coming from a White British background, it was important to reflect on how my background and upbringing may differ to those of my clients. Understanding diversity in the context of clinical practice has been particularly important for a Chinese woman I am working with presenting with depression. During assessment
she has emphasised her physiological symptoms\(^3\) and the cultural/familial expectations of a woman of her age. Reflecting on my client's cultural background gave me greater insight into how to formulate her current difficulties in the context of her cultural background, and how change may be explored with these cultural influences in mind.

**CONCLUSION**

Although developing a presentation on an ambiguous topic was anxiety-provoking, from considering my subsequent clinical experience I appreciate the importance of the task. From reflecting on my own experience of change, and realising my relationship to change has often been one of reluctance and pessimism, I have begun to appreciate the magnitude of the changes we expect from clients. I have also learned to appreciate the importance of the therapeutic relationship, as collaborating with individuals I was unfamiliar with was a challenging task in itself. Both these learning points have enhanced my compassion for the clients I see who struggle to disclose what their difficulties are, or fail to attend appointments as the possibility of change may be too overwhelming. I feel the task has helped me to appreciate the individual experience of change, and the many factors our relationship to change can be influenced by.

\(^3\) Research has shown that Chinese individuals who experience depression often express symptoms somatically due to the cultural stigma of mental health (e.g. Parker et al. 2001).
REFERENCES


APPENDICES

APPENDIX A. Barriers to change model

APPENDIX B. Stages of Change model

APPENDIX C. Theory of reasoned action model
APPENDIX A.

Barriers to change model.
Figure 1 illustrates the 10 areas identified by Burrowes & Needs (2009) that potentially can create barriers to change.

Figure 1. Barriers to change model (Burrowes & Needs, 2009).
APPENDIX B.

Stages of Change model.
Figure 2 illustrates the “stages of change” model, developed by Prochaska & Diclemente (1992), to outline the stages individuals progress through when changing unhealthy behaviours, e.g. smoking. “Precontemplation” refers to stage when an individual does not feel they need to change. “Contemplation” occurs when an individual recognises there is something they need to change, and they intend to do so in the future. At the “Preparation” stage an individual is ready to begin to take action to implement the change. The “Action” stage occurs when an individual has begun to implement the change, and finally the “Maintenance” stage refers to the period of time following successful change (usually 6 months) and the ability to not relapse. At any stage there is the possibility of relapse, where an individual may revert to a previous stage.

Figure 2. Prochaska & Diclemente (1992) Stages of Change model.
APPENDIX C.

Theory of reasoned action model.
Figure 3 illustrates the theory of reasoned action, developed by Azjen & Fishbein (1980) to describe the process of behaviour change.

Figure 3. Theory of reasoned action (Azjen & Fishbein, 1980).
PROBLEM-BASED LEARNING

REFLECTIVE ACCOUNT: CHILD PROTECTION, DOMESTIC VIOLENCE, PARENTING, AND LEARNING DISABILITIES AND KINSHIP CARE.
PROBLEM BASED LEARNING (PBL) TASK

We were given our third problem-based learning (PBL) task at the beginning of the second year, involving a clinical vignette. The vignette outlined the Stride family, including a mother with a learning disability, a father with a possible learning disability who has been physically abusive towards the mother, and three-year-old twin daughters. The Strides were at risk of losing the twins due to possible neglect and emotional abuse. The twins are currently in foster care, and the clinical psychologist has been approached by the children’s Guardian and asked to help the Court by conducting a full risk assessment, and if appropriate, to help the Court develop a rehabilitation plan for the children. We were also asked to consider whose problem is it and why?

Please see appendix A for the genogram of the Strides and outline of the professional network offered as part of the PBL task introduction.

THE GROUP PROCESS

As a PPLD (personal and professional learning discussion) group we agreed that it would be interesting to complete another PBL task together, as we had not completed a task together since the beginning of training. While we felt we had developed well as a group over the year, we wondered whether that would remain when we were engaged in a task and had differing opinions. In my reflective account from the previous PBL task I was aware I had felt unhappy in my previous position in the group for the PBL task and wanted to ensure that in this task I had more of an active role in planning and developing the presentation. I became pessimistic during initial meetings as thoughts/ideas were being discussed, and it felt like my points were often being overlooked. I was grateful when another group member picked up on my mood and re-orientated the group back to the points I made. This felt like a
positive sign of the group’s development, with group members paying attention to individuals and supporting one another, rather than competing.

From the initial meeting there seemed to be a group consensus that we did not want to spend as much time as we did last year worrying about the PBL task, considering the demands of a new placement and learning about new client groups. This reflected the general attitude of our group, which I perceived to be more confident in the role of a trainee clinical psychologist; able to express our opinions on a subject matter without fear of judgement from peers. This change made the conversations feel more reflective about clinical issues, and allowed ideas and debates to develop, rather than focusing on getting the task “right”. Conversely, it sometimes felt that the relaxed attitude resulted in group members putting less effort into the task, with uneven contributions in time spent on the task.

In contrast to the first PBL task our group completed, there was a greater sense of group collaboration; in the first task we developed our individual presentations and presented individually. On this occasion, we developed an outline of the presentation as a group, i.e. the role play content, and then developed specific role play scripts in pairs based on the groups’ decisions regarding the content. This suggested a positive shift in our group development based on the Tuckman & Jensen (1977) stages of group development. During the course of the first year we identified that we remained within the forming and storming stages (see Appendix B) for most of the year. Completing this PBL task confirmed that we had moved into the performing stage, using the group’s interpersonal structure to engage in a group task. We were able to use individual strengths to allocate roles, rather than individuals trying to “take over” the presentation.
In terms of our individual roles, these could be understood using Belbin’s Team Roles Model (1993; see Appendix C). Several group members clearly adopted the role of “Plant”: brainstorming numerous ideas for the presentation, coming up with a TV show-style presentation. One group member adopted the role of “Monitor-Evaluator”: analysing the feasibility of the options put forward by the “Plants”. I identified that myself and another group member adopted an “Implementer” role; putting initial ideas into coherent action plans. I focused on researching different professional perspectives and child protection legislation, necessary for our paired role plays. Collectively, we all held different roles which complemented one another to ensure we met the requirements of the task, while still managing to work as a group rather than independently. While this was similar to my role in the previous PBL task, I also felt I adopted an additional role in this task, becoming more involved in the “Thought-Orientated Role” of the “Specialist”. I used my attendance at some Child Protection training, and my supervisor’s role in the social care team to provide some unique knowledge on the subject. When reflecting on this PBL task several months after the presentation this was reinforced by other group members, who identified my strength in the PBL task as a strong knowledge base, and my ability to communicate complex ideas in a straightforward manner. I’m aware from reflecting on my role in the group that I tend to feel more comfortable in an academic role in the group, whereas other group members have strengths in a creative role. Playing the role of a social worker I realised that I was struggling to step away from the "psychologist" position. Throughout clinical training we are encouraged to work as scientist-practitioners (Lane & Corrie, 2006) by employing research evidence to develop treatment plans. This was dispersed throughout my “social worker” script, referring to psychological approaches/research, as it felt unnatural to form an opinion
on a clinical case without attending to psychological theory and evidence. This was a
general theme amongst the group, with other non-psychologist team members also
appearing very psychologically-minded, e.g. our community psychiatric nurse. Upon
reflection, we wondered as a group whether our role plays were realistic
representations of other professionals’ opinions.

THE PRESENTATION

The increased confidence of the cohort as a whole was evident while
observing the presentations, with a variety of presentation styles incorporated
compared to the previous year. Despite the contrast between the presentation styles,
however, there was a clear underlying theme across the presentations that no one felt
comfortable deciding an outcome for this case. I wonder whether this is a reflection
of us being protected in our trainee roles, whereby we would not usually be working
with a case of this complexity. Certainly as a group we did not feel able to come to a
congrete conclusion, however, this provided us with a unique insight into the sorts of
cases we would be involved in upon qualification.

There was some controversy around the portrayal of the social worker in the
presentations as stereotypical. One audience member even commented that I had
appeared uncomfortable in the role. Stepping into the role of the social worker had
made me aware of my conflicting feelings around my role in the presentation. I was
aware of the social worker’s duty to prioritise the twins’ safety and adopt a child-
centred approach. However, this sat rather uncomfortably with my professional
training which encourages a systemic perspective.
REFLECTIONS FROM CLINICAL PRACTICE

Developing communication skills to meet clients’ needs

During my first week of my CAMHS (Child and Adolescent Mental Health Service) placement I found myself completing part of an assessment with a ten-year-old boy, who was expressing distress at the domestic violence he observed at home. Despite having a number of young children in my family I was struck by how difficult I found it to communicate with a young child about this topic- did I ask directly about the domestic violence? This early experience made me aware of the differing communication styles when working with different client groups. I wondered how staff working with families similar to the Strides engage with children and attempt to build a picture of their perspective when discussing such an emotive and sensitive topic.

I subsequently began working with another case where a young boy had witnessed domestic violence in the home, and was presenting with behavioural difficulties at home and school. This had been a particularly frustrating case to work with during my placement, with the parent (with a possible learning difficulty) reluctant to engage with services and use the information/advice offered. Reflecting on the PBL task in relation to clinical practice has been helpful in this case, whereby I have been able to consider the possibility of whether engagement issues with CAMHS are potentially related to a poor understanding of material presented. As I have not worked with individuals with learning disabilities before, it was useful, as part of the PBL task, to spend some time considering how a learning disability may impact on someone involved with services and whether their needs are adequately considered and met. From researching the area of parenting and learning disabilities I developed much greater empathy for the parents I encounter in clinical practice, and
am better able to consider situations from the parents' perspective. This has been a key skill to have on a CAMHS placement where parents tend to fear being, and sometimes are, blamed for their child's behaviour.

Clinical Decision Making

I was intrigued during some Child Protection training I attended that the facilitator (a social worker) pronounced that the assessment of "good enough" parenting is linked to "experience and intuition". While I appreciate the importance of experience in becoming an effective clinician I felt relieved to be in a profession that, while valuing experience, adopts a scientist-practitioner model, so I have theory and research evidence to draw upon when carrying out work with complex cases. However, when developing the PBL presentation, I was struck by the lack of standard protocol in assessing "good enough" parenting, particularly in a client group where the prejudice is high, i.e. parents with learning disabilities (e.g. Booth, 2004). While there are publications outlining areas to consider it appears the final decision is somewhat subjective. Therefore, part of my reflections on this PBL task also involved the standards by which we judge, not only parents, but clients in general. The task reminded me that our perceptions of our clients are strongly influenced by our own experiences, and I was aware that when discussing "good enough" parenting for the task or in clinical practice that, with a lack of objective criteria, we are inevitably influenced by our own experiences.

This raises important issues for working with difference and diversity: how do we understand the parenting practices of individuals raised with different cultural/religious beliefs or experiences? One such debate which demonstrates this issue is the current dispute around smacking children. Despite being raised in a culture where this is strongly frowned upon, I am aware individuals from other
cultural backgrounds would advocate this as good parental discipline (Irfan, 2008). Hence depending on upbringing/cultural beliefs, a professional’s perception of “physical abuse” would be markedly different. This has highlighted to me the importance of using reflective practice and supervision to monitor how personal experiences/beliefs may impact on my clinical work, particularly in complex cases where there is less concrete guidance.

Labelling

When scanning the literature on parents with a learning disability I was struck by the growing evidence of the prejudice surrounding parents with a learning disability (e.g. Booth, 2004). I felt disappointed from this literature that, for this population, the prejudice also lies within the professionals as well as the general public. The issue of labelling, e.g. learning disability, is a pertinent issue in CAMHS work where I have witnessed and experienced conflicting views on whether to label a child by both professionals and parents. A large part of my psychometric work in CAMHS has involved assessing cognitive abilities in children with “behavioural problems”; usually a learning difficulty is identified which the child has been masking by “playing up”. In these cases I can see how labels can be helpful, allowing the child to access support they need and reach their full potential. However, I am also aware of the possibility that, for example, labelling a child with learning difficulties can lead the child (and others) to lower their expectations and assume themselves incapable, resulting in a self-fulfilling prophecy (Blum & Bakken, 2009).

Forgetting the father

While we originally aimed to cover all the professionals roles outlined in the professional network we opted for a more pragmatic approach, selecting “key” individuals for each role play; Mrs Stride and the community psychiatric nurse, the
social worker and the children's guardian (to consider the child's perspective), and
the psychologist and their supervisor. Upon reflection we realised that, as a group,
we had neglected the father's perspective. Duhig, Phares & Birkeland (2002) also
identified that fathers are less involved in therapy than mothers. This has certainly
been evident in my own experience of CAMHS, whereby only one client attends
appointments with their father. As a trainee I appreciate I have been able to reflect on
this significant issue at an early stage, and ensure I encourage involvement of both
parents in clinical practice. Since reflecting on this task, I have endeavoured to
ensure that even when fathers are not physically present their perspective is kept in
mind and referred to.

**CONCLUSIONS**

Completing this PBL task was beneficial for the development of our PPLD
groups, as well as the opportunity to consider a clinically relevant and complex PBL
task. As a PPLD group we had the opportunity to compare how we worked as a
group at two points in time, based on our group development over a year.
Furthermore, working on this vignette gave me some important learning points and
reflections to bear in mind during my current and future clinical practice,
specifically: the challenges of adapting to the communication needs of clients, the
subjectivity of clinical decision making, diagnostic labelling, and remembering the
father in clinical practice.
REFERENCES


APPENDICES

APPENDIX A. Outline of the Stride family and professional network

APPENDIX B. Stages of small group development

APPENDIX C. Belbin’s Team Roles Model
APPENDIX A.

Outline of the Stride family and professional network.
Below summarises the information offered to the group on the Stride family and the professional network. Figure 1 is a genogram identifying the Stride family structure. Figure 2 is an ecomap representing the professionals involved.

**Figure 1. The Stride Family genogram**

**Figure 2. The Professional network**
APPENDIX B.

Stages of small group development.
Figure three offers a diagrammatic illustration of the stages of small group development as theorised by Tuckman & Jensen (1977).

![Stages of small group development](image)

Figure 3. Stages of small group development (Tuckman & Jensen, 1977).
APPENDIX C.

Belbin’s Team Roles Model.
Figure four outlines the nine roles from Belbin’s (1993) model of team roles.

They are clustered into three role orientations: action, people, and thought.

<table>
<thead>
<tr>
<th>Action-Oriented Roles</th>
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<tbody>
<tr>
<td><strong>Shaper</strong>: Facilitates team improvement</td>
</tr>
<tr>
<td><strong>Implementer</strong>: Puts ideas into action</td>
</tr>
<tr>
<td><strong>Completer Finisher</strong>: Ensures task completed accurately and on time</td>
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<table>
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<tr>
<th>People-Oriented Roles</th>
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</thead>
<tbody>
<tr>
<td><strong>Coordinator</strong>: The &quot;chairperson&quot;</td>
</tr>
<tr>
<td><strong>Team Worker</strong>: Ensures team collaboration</td>
</tr>
<tr>
<td><strong>Resource Investigator</strong>: Investigates opportunities for outside resources</td>
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<table>
<thead>
<tr>
<th>Thought-Oriented Roles</th>
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</thead>
<tbody>
<tr>
<td><strong>Plant</strong>: Develops ideas</td>
</tr>
<tr>
<td><strong>Monitor-Evaluator</strong>: Assesses feasibility of ideas</td>
</tr>
<tr>
<td><strong>Specialist</strong>: Provides specialist knowledge/skills for task</td>
</tr>
</tbody>
</table>

Figure 4. Belbin’s Team Roles Model (Belbin, 1993).
PERSONAL AND PROFESSIONAL LEARNING DISCUSSION GROUP (PPDLG) PROCESS ACCOUNT SUMMARY 1.

PERSONAL AND PROFESSIONAL LEARNING DISCUSSION GROUP

SEPTEMBER 2011

YEAR II
The PPDLG process account summarises how the group has developed over the first year of training. The groups are set up as a space for trainees to discuss issues from placement, university, or personal matters. I have discussed my role within the group in comparison to my role on placement and in other university groups I have been involved in.

As a group we initially started out as highly structured and task-focused, which led to discomfort once the tasks ended and we had unstructured sessions. Over the year we have learned how we want the groups to be run, although there were disagreements between group members regarding how structured the sessions should be.

From taking part in this group I have learned about my own role in groups, how the group has influenced this role, and what I would like my role to be. I have appreciated the opportunity to learn from other group members about their experiences, but have been frustrated at times as some group members tend to take over the group.

Writing this account has been helpful for me to reflect on the past year, specifically on the PPDLG sessions, and consider what I would like to gain from future PPDLG sessions. I hope in future groups I will take the opportunity to benefit from this forum more than I have so far, in order to gain valuable peer support as well as the opportunity to gain multiple perspectives on any dilemmas I may face.
PERSONAL AND PROFESSIONAL LEARNING DISCUSSION GROUP (PPDLG)
PROCESS ACCOUNT SUMMARY 2.

PERSONAL AND PROFESSIONAL LEARNING DISCUSSION GROUP

JULY 2012

YEAR II
The PPDLG process account summarises how the group has developed over the second year of training. The groups began in the first year of training as a forum for discussing any issues arising on placement, at university, or in our personal lives. My process account details the challenges we faced as a group in the second year, in the context of changing facilitator and a group member taking long-term leave.

As the second year progressed we often resorted to silence and became less willing to bring material to the group. A rare opportunity to hold the group informally without a facilitator allowed us to be open and honest with one another about why we had all struggled to contribute to the group and re-define what we hoped to gain from the group.

From attending the group I have been able to explore my own experiences of working in the NHS, and faced the challenge of allowing myself to be open and vulnerable in the group. This has given me the opportunity to reflect on the challenges my own clients might face in being open and vulnerable in therapy sessions, and the potential risks of being involved in a reflective group in clinical practice.

Although it felt as though the group was unhelpful at times, I anticipate this has been a valuable learning experience to define what we hope to gain from our third and final block of PPDLG sessions.
CLINICAL DOSSIER

CORE ADULT MENTAL HEALTH PLACEMENT

CORE CHILDREN, ADOLESCENTS AND FAMILIES PLACEMENT

CORE OLDER ADULTS PLACEMENT

CORE PEOPLE WITH LEARNING DISABILITIES PLACEMENT

SPECIALIST PLACEMENT IN INTERPERSONAL PSYCHOTHERAPY
ADULT MENTAL HEALTH

Date: October 2010 – September 2011

Location: West Battersea Community Mental Health Team, The Mapleton Centre, Wandsworth, London SW18 4DD

Supervisor: Dr Nicolette De Villiers

Summary of Experience Gained: The placement involved working in a Community Mental Health Team (CMHT) and an inpatient unit with individuals with both acute and long-term mental health problems (age range 20 – 75). Individual cognitive behavioural therapy (CBT) was undertaken with nine clients in the community. Narrative therapy was also undertaken with one client. On the inpatient unit brief interventions were provided to three individuals and two families using a systemic consultation model. A group was also co-facilitated on the inpatient unit using a cognitive behavioural framework for managing admission to and discharge from the ward and time spent on the ward. Presenting difficulties included: depression, bipolar affective disorder, obsessive compulsive disorder, borderline personality disorder, and schizophrenia (and other psychoses). Neuropsychological assessments were completed with three individuals. Tests used included the WAIS-III, the WMS-III, and the TONI-4. Three teaching/reflective practice sessions were offered to staff working in the CMHT. A workshop on psychosis was also presented to a community from a BME group. A service-related research project was completed during this placement on service user satisfaction with an inpatient family clinic. This project was presented as part of a workshop on working with families on an inpatient unit at the national Association of Family Therapy conference in September 2011.
CHILD AND ADOLESCENT MENTAL HEALTH

Date: October 2011 – March 2012

Location: Child and Adolescent Mental Health Service, Birches House, Birches Close, Cricket Green, Mitcham, Surrey CR4 4LQ

Supervisor: Dr Anila George & Dr Nicole Letch

Summary of Experience Gained: Individual CBT for anxiety was completed with three clients (two boys and one girl). Other interventions used were play therapy, dialectical behavioural therapy, emotion regulation work, life story work, and narrative therapy. Presenting difficulties included self-harm, obsessive compulsive symptoms, school anxiety, specific phobias, and generalised anxiety. Psychometric assessments were undertaken with four clients. Tests included the WIPPSI, WISC-IV, and WMS-IV. Inter-disciplinary/consultation meetings with schools were a regular part of the work. A teaching session was provided at a psychology team meeting on the future of clinical psychology in the NHS.
OLDER ADULT MENTAL HEALTH

Date: April 2012 – September 2012

Location: Older Adults Psychology Service, Farnham Road Hospital, Farnham Road, Guildford, Surrey, GU2 7LX

Supervisor: Dr Philip Anderson

Summary of Experience Gained: Individual CBT was completed with three clients, with presenting difficulties including depression with psychosis, panic disorder, and bipolar affective disorder. An extended assessment and consultation was provided to a nursing home around a woman with behaviour that challenged and generalised anxiety. Neuropsychological assessments were completed with two clients showing signs of dementia, using a battery of neuropsychological tests. Involvement in service development included developing a dementia booklet on the environment as part of a dementia pack. Other activities included visiting a dementia cafe with Friends with Dementia, a day hospital for older adults and a support group for carers of individuals with dementia.
LEARNING DISABILITIES

Date: September 2012 – September 2013

Location: Psychology and Challenging Needs Service, Sessions House, 17 Ewell road, Surbiton, Surrey KT6 6AF

Supervisor: Dr Jane Major

Summary of Experience Gained: Two learning disabilities assessments and three dementia assessments (one baseline assessment and two follow-up assessments) were completed, using a range of assessment tools: WAIS-IV, BDI, BAI, ABAS-II, DRS-II, Oliver & Crayton neuropsychological assessment, CORE-LD, DLD, and HALO. Extended assessments (six sessions) were completed with four individuals affected by a learning disability. Two pieces of consultation work were completed with care staff using a systemic framework. A “managing worries” group for individuals affected by a learning disability and anxiety was co-facilitated. Long-term individual therapy using a systemic framework was carried out with two female service users in their twenties affected by a learning disability. Couple therapy was also completed with two housemates, where one presented with behaviour that challenged the staff team and housemates.
SPECIALIST PLACEMENT:
INTERPERSONAL PSYCHOTHERAPY

Date: September 2012 – September 2013
Location: Wolverton Centre, Kingston Hospital, Galsworthy Road, Kingston upon Thames, Surrey KT2 7QB

Supervisor: Ms Louise Deacon

Summary of Experience Gained: Ten initial assessments were completed with individuals referred to the psychology team. Interpersonal Psychotherapy was completed with five individuals accessing the sexual health clinic, with symptoms of depression. Clients were assessed using the PHQ-9 and the GAD-7. Behavioural activation work was completed with a gentleman living with HIV, who was severely depressed. Behavioural therapy was also completed with a woman presenting with vulvodynia and mild symptoms of depression and anxiety. Systemic couples work was completed with a married gentleman at risk of contracting HIV and his wife, exploring communication and stress in the marital relationship. A presentation was delivered to the sexual health staff team on the role of IPT in a sexual health clinic.
RESEARCH DOSSIER

RESEARCH LOG

QUALITATIVE RESEARCH PROJECT: “How do young adults view celebrities with mental health difficulties?”

SERVICE RELATED RESEARCH PROJECT: “Service user and family feedback on an inpatient Family Clinic: a service evaluation.”

MAJOR RESEARCH PROJECT: “An interpretative phenomenological analysis on the experience of parenting and being parented for mothers diagnosed with Borderline Personality Disorder.”
1. Formulating and testing hypotheses and research questions

- Qualitative research project (QRP) involved developing a research question and identifying how this could be tested, i.e. by developing an interview schedule.

- Service-related research project (SRRP) involved identifying a research question which could assess the satisfaction with a service set up on an inpatient unit.

- Major Research Project (MRP) involved identifying research questions and aims based on a literature search, then developing an interview schedule to explore the aims.

2. Carrying out a structured literature search using information technology and literature search tools

- The QRP, SRRP and MRP required a literature search prior to completing the projects to assess for whether similar ideas had been researched previously and how previous projects could be improved upon. The literature search involved using a range of electronic databases available on the university intranet to search key terms.

3. Critically reviewing relevant literature and evaluating research methods

- The literature review assignment involved reviewing and critiquing previous literature and the methods employed.

- Literature searches were also conducted as part of SRRP and MRP literature review, to assess for pre-existing literature and a background understanding of the field in order to develop a research question.

4. Formulating specific research questions

- Research questions were formulated as part of my MRP proposal, QRP and SRRP.

5. Writing brief research proposals

- The SRRP involved writing up a brief research proposal to ensure the project was acceptable for the SRRP.
6. Writing detailed research proposals/protocols - The MRP process included developing a research proposal which was reviewed by a panel of both clinical and academic professionals. This was subsequently reviewed by two ethics committees and given a favourable opinion (University and NHS).

7. Considering issues related to ethical practice in research, including issues of diversity, and structuring plans accordingly - As my SRRP involved service users on an inpatient unit I had to consider the issue of informed consent. To assess the situation my supervisor and I discussed how this issue may be handled.

- As my MRP involved recruiting individuals with a history of childhood trauma/abuse and possible child protection issues I had to ensure this was addressed in my ethics application. A plan of action was set up if any issues of risk were disclosed.

8. Obtaining approval from a research ethics committee - A research ethics committee was approached and reviewed my MRP proposal. Following some minor amendments it was given favourable opinion by the ethics committee.

9. Obtaining appropriate supervision for research - I sought out appropriate supervision for my MRP in terms of both theoretical and methodological knowledge. This included seeking a university supervisor and an external/field supervisor.

10. Obtaining appropriate collaboration for research - In agreement with my supervisor I have attended team meetings regularly with my recruitment service to build links and enhance the collaborative process. This included approaching several recruitment sites during the research process.

11. Collecting data from research participants - I have interviewed participants for my QRP and MRP. I also distributed questionnaires for my SRRP.
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<tbody>
<tr>
<td>12. Choosing appropriate design for research questions</td>
</tr>
<tr>
<td>13. Writing patient information and consent forms</td>
</tr>
<tr>
<td>14. Devising and administering questionnaires</td>
</tr>
<tr>
<td>15. Negotiating access to study participants in applied NHS settings</td>
</tr>
</tbody>
</table>
| 16. Setting up a data file | - As part of the research methods teaching module I took part in teaching seminars that included setting up a data file.  
- I also set up a data file as part of my SRRP project. |
<p>| 17. Conducting statistical analysis using SPSS | - As part of the research methods teaching module I took part in teaching seminars that included conducting statistical analyses using SPSS. |
| 18. Choosing appropriate statistical analyses | - As part of the research methods teaching module I took part in teaching seminars that included choosing appropriate statistical analyses using SPSS. |
| 19. Preparing quantitative data for analysis | - As part of the research methods teaching module I took part in teaching seminars that involved preparing quantitative data for analysis using SPSS. |</p>
<table>
<thead>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>20. Choosing appropriate quantitative data analysis</td>
<td>• As part of the research methods teaching module I took part in teaching seminars that included choosing appropriate statistical analyses using SPSS.</td>
</tr>
<tr>
<td>21. Summarising results in figures and tables</td>
<td>• I presented data in appropriate figures/tables for my SRRP and my MRP.</td>
</tr>
<tr>
<td>22. Conducting semi-structured interviews</td>
<td>• I conducted semi-structured interviews for my QRP and MRP.</td>
</tr>
<tr>
<td>23. Transcribing and analysing interview data using qualitative methods</td>
<td>• I transcribed interview data and subsequently analysed it as part of my QRP and my MRP.</td>
</tr>
<tr>
<td>24. Choosing appropriate qualitative analyses</td>
<td>• I selected the appropriate analysis for both my QRP and MRP.</td>
</tr>
<tr>
<td>25. Interpreting results from quantitative and qualitative data analysis</td>
<td>• I interpreted the results generated from my SRRP, QRP, and MRP (both qualitative and quantitative).</td>
</tr>
<tr>
<td>26. Producing written reports on a research project</td>
<td>• I produced a written report for my QRP, SRRP and MRP.</td>
</tr>
<tr>
<td>27. Defending own research decisions and analyses</td>
<td>• For my MRP I met with a peer review panel and an ethics review panel, which involved defending my research decisions.</td>
</tr>
</tbody>
</table>
28. Applying research findings to clinical practice

- My SRRP included a section on the application of the findings to clinical practice.
- My MRP included a section on applying the research findings to clinical practice, training, policy, and supervision.

29. Submitting research reports for publication in peer-reviewed journals or edited book

- I co-authored several research reports for peer-reviewed journals during training for research I completed pre-training:


• The QRP was co-presented on clinical training.

• I presented my SRRP at a team meeting and at a national conference as part of a workshop:


• I also presented research I completed as an assistant psychologist at a national conference in my final year of training:

ABSTRACT

Objective Celebrities with mental health difficulties are often asked to participate in campaigns to challenge discrimination against those with mental health problems, for example the national ‘Time to Change’ anti-stigma campaign. However, there has been little research into public attitudes towards celebrities with psychiatric problems. This study therefore aimed to explore views of celebrities with a mental illness.

Design Four young adults each participated in a 25-minute semi-structured face-to-face interview which was then transcribed. A realist position was adopted and thematic analysis was used to code and analyse the transcripts.

Results Four central themes were identified in the data: (i) Celebrities’ difficulties were seen as disingenuous as they were believed to benefit from ‘acting crazy’, for example by attracting attention to themselves; (ii) celebrities’ problems were seen as shallow and artificial; (iii) celebrities were thought to largely self-inflict their difficulties on themselves through substance abuse or reckless behaviour; (iv) while participants recognised that media reports are sensationalised and inaccurate, they felt distant from celebrities, thus viewing their mental health difficulties as a source of entertainment.

Conclusions A critique of the study and research methodology is presented, but it is suggested that national campaigns aiming to reduce discrimination against those with mental health difficulties may wish to be cautious about their use of celebrity stories, as these will not necessarily engender understanding or empathy.
SERVICE USER AND FAMILY FEEDBACK ON AN INPATIENT FAMILY CLINIC: A SERVICE EVALUATION.

SERVICE-RELATED RESEARCH PROJECT

JULY 2011

YEAR I
Thank you to the Family Clinic team (Nicolette De Villiers, Billie Lever Taylor, Estelle Barker and Kathy Miller) for distributing my questionnaires, and to my supervisor Nicolette De Villiers for assisting with the questionnaire development.

Thank you also to my SRRP supervisor Laura Simonds for her assistance in developing this service evaluation.

Finally, thank you to Roger Stanbridge and colleagues at the Somerset Family Interventions Services for granting me permission to adapt their questionnaire for my service evaluation.
ABSTRACT

Background The Family Clinic was set up on two adult psychiatric inpatient wards in 2005 to provide a space for individuals and family members following an admission. While the Family Clinic has been running for six years, so far there has been no feedback evaluation of the service.

Objective The objective of the service evaluation was to gain feedback from individuals on their experience of attending the Family Clinic.

Method A questionnaire was adapted from a previous evaluation of a family service by Stanbridge et al. (2003). Over a four month period 14 service users and 12 family members completed a feedback questionnaire.

Results The results showed that all participants were partially or very satisfied with their session with the Family Clinic. Ward staff and Family Clinic staff were the main sources of information and referral to the service. Service users found that “someone to listen to them” was the most helpful aspect of the session and “helping the family interact”. Family members found the “opportunity for family discussion” was most helpful. “More therapist feedback” and “longer sessions” were most commonly identified as aspects that could be improved.

Conclusions The Family Clinic is a valued service by both service users and family members. Participants appreciated the opportunity to have a space to communicate, either with professionals or within the family. The Family Clinic needs to promote the service to other staff groups, e.g. community staff or psychiatrists, to encourage more referrals.
BACKGROUND

Psychiatric inpatient admissions are a stressful time for both service users and family members, with some service users describing their time as inpatients as terrifying and scary (Gilburt, Rose & Slade, 2008). Carers have described feeling powerless and isolated during the service user’s admission, with a lack of information or involvement in care (Wilkinson & McAndrew, 2008).

The Department of Health (2002) published a document outlining the current issues with acute inpatient care and how services can improve. They also identified that there is a lack of information on what is available to, and what is expected of, both service users and family members. The report also suggests inpatient services should facilitate contact with and support from “normal” sources in the community, including family and/or carers. As Bowers (2005) identified severe mental illness as one of the main seven reasons for admission to an acute ward and NICE guidelines recommend the use of family interventions for severe mental illness (Bipolar Disorder and Schizophrenia: NICE, 2006; NICE, 2009), it appears family input should be a vital part of an inpatient admission. However, a survey by Stanbridge & Burbach (2007) revealed 82% of inpatient staff surveyed (from nine units) had received no training in family work and only 19% felt confident working with families, indicating a lack of competence among staff in family work.

Service user feedback evaluations in family services have received little attention in the literature, with an emphasis on clinical outcomes instead (see Carr, 2009, for a review). A previous service evaluation by the Family Support Service\(^4\) (Stanbridge et al., 2003) used an interview method to understand the helpful and unhelpful aspects of their service, e.g. families developed new skills, but felt they

\(^4\) This team is responsible for setting up the other inpatient family service in the UK.
were referred too late. However, the researchers combined service user and family member responses, making it difficult to ascertain whether there were differences between each group’s experiences of the service.

The Family Clinic

The Family Clinic is one of two identified teams in the UK that have set up an inpatient service specifically for families. The Family Clinic was set up on two psychiatric inpatient units in 2005, to offer service users and their families a space to “reflect on the impact of the admission on their relationships and to help strengthen these networks” (page 3; De Villiers, 2009). Due to the high turnover of inpatients the Family Clinic employs a consultation model; providing “stand-alone” sessions to service users and/or families. The Family Clinic staff also employ the “reflecting team” technique as a way of offering feedback to families. The Family Clinic team consists of two qualified family therapists, with ward staff, community staff and students also invited to take part in the sessions.

A report on the service (De Villiers, 2009) recommended the service develop a routine way of evaluating patient and family satisfaction with the Family Clinic. The Family Clinic has now been running for six years and so far there has been no feedback evaluation. It remains unclear whether users of the service are satisfied with the current set-up, and whether there are any adjustments that would improve their experience of the Family Clinic.

OBJECTIVE

The objective of the service evaluation is to gain feedback from individuals on their experience of attending the Family Clinic. The service evaluation will focus on the information and referral pathway, the session content, and session outcome.
METHOD

As there was no known evaluation tool available to assess the use of a systemic model on an inpatient unit and the Family Clinic had not yet developed a tool, interview questions from the Family Support Service evaluation were adapted into a questionnaire format (Stanbridge et al. 2003).

While interviewing would have been a preferable method for the service evaluation, the time constraints of the evaluation did not allow for such an in-depth method. Additionally, it was assessed to be more efficient to use questionnaires as a self-completion method was likely to enhance sample sizes.

Measure

Questions were added to the Family Support Service interview schedule (Stanbridge et al. 2003) to address specific aspects of the Family Clinic, e.g., the reflecting team. The revised questionnaire was circulated for comments to the university supervisor, field supervisor, and Family Clinic team. Additionally, it was piloted with three inpatients to assess ease of completion. The final version of the questionnaire can be found in appendix A.

Procedure

The questionnaire was distributed over a period of four months, during which 15 Family Clinic sessions were available. Fifteen service users and thirteen family members were approached during this period. Following each session individuals/families were given a rationale for the questionnaire; to facilitate service user and family feedback in order to improve upon and develop the Family Clinic. Service users and family members were informed participation was voluntary, and the decision not to take part would not affect the service they received from the team. If they agreed they were given the questionnaire at the end of the session to complete.
and return to a Family Clinic staff member. Alternatively they could take away the questionnaire and return to ward staff. Completed questionnaires were placed in a folder to ensure confidentiality.

**Ethics**

Ethical approval was not deemed necessary for this study as it was assessed as a service evaluation rather than research, due to its focus on measuring current practice within the Family Clinic, and its restriction to improving the Family Clinic rather than generalising to other services.

The ethical consideration of distributing questionnaires to vulnerable individuals (who may not have capacity to consent) was deliberated. To monitor this, staff in the Family Clinic liaised with ward staff to ensure those individuals who attended sessions were deemed well enough to engage in a therapeutic session; hence it seemed reasonable to assume those who attended the clinic had capacity to consent to completing the questionnaire.

**RESULTS**

The response rate for the questionnaires was 93%; including 14 service users and 12 family members. Table 1 summarises the demographical information available on the participants.

**Table 1. Demographical information of participants.**

<table>
<thead>
<tr>
<th>Participants</th>
<th>Mean age (range)</th>
<th>Gender</th>
<th>Ethnic origin&lt;sup&gt;5&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Females</td>
<td>Males</td>
</tr>
<tr>
<td>Service users</td>
<td>14</td>
<td>40.9 (20-70)</td>
<td>10</td>
</tr>
<tr>
<td>Family members</td>
<td>12</td>
<td>57.8 (33-71)</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>48.7 (20-71)</td>
<td>16</td>
</tr>
</tbody>
</table>

<sup>5</sup> WB= White British     BME= Black and Minority Ethnicities
See appendix B for the data and percentiles from the questionnaires. Service user responses and family member responses were equated collectively and separately, to allow for descriptive comparisons to be made. Qualitative data obtained from the open-ended questions in the questionnaire was analysed using content analysis.

Sources of information and the referral pathway

As illustrated by figure 1, family members usually had no knowledge of the purpose of the Family Clinic prior to the session, or understood it to be a place to discuss the service users’ problems. Service users most commonly understood it to be a place to receive help for the family or to receive advice.

![Figure 1. Participants' knowledge of the Family Clinic prior to the session.](image)

The majority of individuals found out about the Family Clinic through staff on the ward (56%), with ward staff being the main source of information for service users (53%) and family members (58%). Service users were five times more likely than family members to find out about the service from the Family Clinic team (40% vs. 8% respectively). Only one service user was informed of the Family Clinic via
ward round, with 25% of family members finding out about the Family Clinic from the service user rather than staff. Ward leaflets and community staff were not identified by participants as sources of information.

Ward staff were also most likely to refer individuals to the Family Clinic or arrange their appointment (service users, 50%; family members, 60%). For service users, this was closely followed by Family Clinic staff (39%). Again, other resources were seldom identified as referral routes by service users or family members.

Content of the session

Satisfaction with the session Service users (SU) and family members (F) were satisfied with their Family Clinic session, with 81% reporting they were very satisfied, and 19% reporting they were partially satisfied.

The therapist/s

Ninety-two per cent of participants reported they felt understood by the therapist/s from the Family Clinic. Two participants, both service users, reported they felt partly understood by the therapists (8%).

Aims of the session

Table 2 summarises who participants believed had decided on the aim of the meeting.

Table 2. How did participants think the aims of the meeting were arrived at?

<table>
<thead>
<tr>
<th>Aim of the meeting</th>
<th>SU (%)</th>
<th>F (%)</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mutually agreed</td>
<td>71</td>
<td>31</td>
<td>50</td>
</tr>
<tr>
<td>Therapist decided</td>
<td>21</td>
<td>25</td>
<td>23</td>
</tr>
<tr>
<td>Family decided</td>
<td>7</td>
<td>25</td>
<td>17</td>
</tr>
<tr>
<td>Missing data</td>
<td>0</td>
<td>19</td>
<td>10</td>
</tr>
</tbody>
</table>
Service users most frequently reported that the family and the therapist/s mutually agreed on the aim of the session. In contrast, as illustrated in table 2, family members' responses were distributed evenly over the three responses.

**Helpful aspects of the session**

As illustrated by table 3 there were some differences between service users and family members.

**Table 3. What did participants find helpful about the session?**

<table>
<thead>
<tr>
<th></th>
<th>SU (%)</th>
<th>F (%)</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding therapist</td>
<td>17</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>Someone to listen to me</td>
<td>21</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>Opportunity for family discussion</td>
<td>13</td>
<td>23</td>
<td>18</td>
</tr>
<tr>
<td>Useful information given</td>
<td>6</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Clearer understanding of ward life</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Important issues discussed</td>
<td>13</td>
<td>19</td>
<td>16</td>
</tr>
<tr>
<td>Trustworthy therapist</td>
<td>15</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>Helped manage problems in family</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Helped me interact with family</td>
<td>13</td>
<td>6</td>
<td>10</td>
</tr>
</tbody>
</table>

Service users commonly found that someone to listen to them was most helpful, whereas family members often reported the opportunity for family discussion was the most helpful aspect of the session. Both groups found that an understanding and trustworthy therapist was helpful, as well as discussing important issues.

**Making sense of the admission**

The majority of service users reported that the session did not help to make sense of the admission (50%), with only 21% reporting that it did. Most family members did not answer this question (58%), with 25% of family members reporting it did help make sense of the admission.
The reflecting team

Most participants agreed the reflecting team was a helpful part of the session, with some participants also reporting it was easy to understand and interesting (see Figure 2). Only two individuals, both service users, reported they found the experience weird.

![Figure 2. What was participants' experience of the reflecting team?](image)

Improving the Family Clinic

As seen in figure 3, service users requested improvements more frequently than family members. Service users and family members would have liked more therapist feedback and longer sessions. Service users also requested for more information to be given.
Figure 3. What would participants improve about the Family Clinic?

Outcome of session

The majority of individuals were offered follow-up sessions and this was the outcome they wanted (85%). Two individuals wanted a follow-up session but were not offered one as the service user was due to be discharged from the ward (12%). One individual reported they were offered a follow-up but did not want one.

Additional comments

Two service users’ responses were communicating their appreciation of the time/space, with another two service users commending the Family Clinic as a beneficial service to be offered as an inpatient. One family member used the space as a summary of the session, another indicated they would have appreciated another session, and the final family member identified that it would have been beneficial to be referred sooner.

DISCUSSION

Similar to the feedback from Stanbridge et al.’s (2003) service evaluation, the feedback was largely positive, however, reporting service user and family feedback separately allowed for comparisons between the two groups and recognition of each
group’s needs. Both services, however, included small sample sizes indicating a longer data collection period is necessary to gain a representative sample.

From the feedback it is clear the ward staff are a valuable asset to the promotion of the Family Clinic, as they were responsible for a large number of referrals. Despite being an asset in informing people of and referring to the service, it seems from the participants’ prior knowledge that ward staff are not providing individuals with sufficient information about the service. Furthermore, the knowledge reported by family members indicated they believed the Family Clinic focussed on the service user, rather than the family as a unit, which could potentially lead to further stigmatisation of the service user as the “problem” in the family.

The therapist qualities appeared to be an important part of the service, with both service users and family members identifying a trustworthy and understanding therapist was a helpful feature of the session. Furthermore, the positive feedback regarding the reflecting team and the request for more therapist feedback suggests the therapists are a significantly important feature of the session.

Additionally the Family Clinic seemed to be appreciated for its capacity for communication between service users and family members. Service users identified the usefulness of having someone to listen to them as an individual or as an opportunity to communicate with family members. This may suggest there is a lack of opportunity for individual or family discussion with ward staff on the inpatient unit; hence individuals appreciate a dedicated space for discussion. This would also explain the request for longer sessions from participants. Unfortunately, it seemed the Family Clinic did not assist with helping to understand the admission or ward life, which was identified as an aim of the Clinic.
Despite offering stand-alone sessions most participants were offered a follow-up session, suggesting most individuals/families have the opportunity to engage with this service over a period of time. This is important in light of research suggesting that severe mental health problems— as seen on acute wards— require more intensive psychological input (over a number of sessions) compared with less severe mental health problems (e.g. Miklowitz, Otto, Wisniewski, et al. 2006). Individuals who were not offered further sessions were being discharged and were being followed up in the community for a referral to individual/family therapy indicating continued therapeutic input.

The Family Clinic is clearly an innovative and appreciated service on the inpatient units. To advocate the benefits of this service on wards the results of this service evaluation will be fed back in a workshop aimed to illustrate “extraordinary practice in ordinary circumstances” using family approaches.

Limitations

Patient satisfaction surveys are commonly criticised, particularly for their questionable validity and problematic designs (Barker, Pistrang & Elliot, 2002). As there was no specific tool available to the service a family support service evaluation tool was adapted, indicating there may be issues with validity and reliability. To overcome this issue it is anticipated, as a larger sample of participants are gathered, an evaluation of the tool will be conducted to assess for reliability and validity.

Following on from this, another important limitation was the number of questionnaires included. While the response rate was high, there were not as many families seen during the data collection period as anticipated due to staff absence.

As most individuals chose to complete the questionnaire at the end of the session in the presence of the Family Clinic staff, it may have increased the
likelihood of socially desirable answers. It was decided this was preferable to individuals taking the questionnaires and failing to return them at a later date.

There was also a gender bias towards women in the evaluation, which is possibly due to one of the Family Clinic staff working on the women’s ward, and promoting the Family Clinic to more individuals/families.

**Recommendations**

A summary of the service evaluation was fed back to the Family Clinic team during a supervision meeting, and to ward staff during a team meeting, to indicate strengths, recommendations, and the use of the feedback questionnaires in future (see Appendix C). A key recommendation fed back was to continue to collect feedback questionnaires from individuals attending the Family Clinic, to increase the sample size. Also, once a larger sample size is achieved to evaluate the questionnaire for reliability and validity.

Following discussion of the service evaluation it was agreed that the questionnaire would be reviewed by the lead researcher and the lead from the Family Clinic to incorporate more open-ended questions. By doing so it would provide information on why participants selected certain responses, e.g. what was helpful about the reflecting team, why were some service users partially satisfied, etc.

It was also recommended that the Family Clinic team spend some time on the ward or in the community promoting the service to staff groups, and clearly defining what the service offers individuals and who is appropriate to refer. Increased distribution and display of Family Clinic leaflets was recommended as another more efficient method, particularly for providing information to family members coming onto the ward.
Another recommendation fed back was that the Family Clinic team could increase the frequency of the reflecting team conversations during the session to meet the request for more therapist feedback. Similarly, as the sessions did not appear to assist with understanding admission or ward life (one of the aims of the Family Clinic) it could be highlighted during the introduction that this may be helpful to consider during the session due to service users’ current situations.

CONCLUSION

Inpatient admissions can be a stressful time for both the individual and their family; therefore providing a space for families to explore relationships seems both important (as suggested by NICE guidelines) and appreciated by service users and families alike. Participants clearly appreciated the opportunity for a space to communicate, either for the individual or the family as a unit, and identified therapist qualities as important for the session. Unfortunately there appears to be limited referral routes and sources of information for service users and their family, which the Family Clinic team need to address through promotion and consultation with staff groups.
REFERENCES


APPENDICES

APPENDIX A. Service evaluation questionnaire

APPENDIX B. Raw data

APPENDIX C. Evidence of SRRP feedback
APPENDIX A.

Service evaluation questionnaire.
Family Clinic Questionnaire

Are you/were you:

Staying on the ward? □

A family member of someone staying on the ward? □

A friend of someone staying on the ward? □

Age: (please state) .......... Gender: Male □ Female □

Ethnicity:

WHITE Caribbean □

British □ African □

Irish □ Any other Black background □

Any other White background CHINESE or OTHER ETHNIC GROUP □

MIXED Chinese □

White and Black Caribbean □ Any other ethnic group (please state) □

White and Black African □

White and Asian □ ..................................................

Any other Mixed background DO NOT WANT TO SAY □

ASIAN or ASIAN BRITISH Indian □

Pakistani □

Bangladeshi □

Any other Asian background □

BLACK or BLACK BRITISH 129
1. How did you find out about the Family Clinic?

<table>
<thead>
<tr>
<th>Option</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Key nurse</td>
<td></td>
</tr>
<tr>
<td>Ward staff</td>
<td></td>
</tr>
<tr>
<td>Ward leaflet</td>
<td></td>
</tr>
<tr>
<td>Ward round</td>
<td></td>
</tr>
<tr>
<td>Family Clinic team</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Community staff</td>
<td></td>
</tr>
</tbody>
</table>

(Please state ..................................)

2. From what you were told (or read) about the Family Clinic, what was your understanding of what the Family Clinic was for, and what we do?

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

3. Do you know who referred you to/arranged your appointment with the Family Clinic?

<table>
<thead>
<tr>
<th>Option</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrist</td>
<td></td>
</tr>
<tr>
<td>Ward staff</td>
<td></td>
</tr>
<tr>
<td>I asked for an appointment</td>
<td></td>
</tr>
<tr>
<td>Community staff</td>
<td></td>
</tr>
</tbody>
</table>

(Please state .........................)
4. How satisfied are you with the service you received from the Family Clinic?

Very Satisfied □ Partially Dissatisfied □
Partially Satisfied □ Very Dissatisfied □

5. Did you feel understood by the therapist/s?

Yes □ Partly □ No □

6. How were the aims of the meetings arrived at?

Family decided □ Therapist decided □ Mutually agreed □

7. What was your experience of the reflecting team conversation at the end of the session (if you observed one)? Please tick all those that apply.

Helpful □ Too short □
Unhelpful □ Weird □
Interesting □ Too long □
Difficult to follow/understand □ Easy to follow/understand □
Not applicable □ Other (…………………………) □

8. What did you find helpful about the session? Please tick all those that apply.

Understanding therapist □ Trustworthy therapist □
Someone to listen to me □ Helped manage problems in family □
Opportunity for family discussion □ Helped me interact with family □
Useful information given □ Other (please list)
Clearer understanding of ward life □ .......................... □
Important issues discussed □ .......................... □
9. What additional aspects could have added to the session? Please tick all those that apply.

Flexible appointment time’s □ Shorter session □
Information given □ Other (please list)
More therapist feedback □ ........................................... □
Longer session □ ........................................... □

10. Did the session help you make more sense of this admission to the ward?
Yes □ Partly □ No □

11. Were you offered follow-up sessions?
Yes, and I’d like more sessions □ No, and I’d like more sessions □
Yes, but I don’t want more sessions □ No, but I don’t want more sessions □

12. Any other comments? (Please write the question number if it relates to one of the previous questions you answered).

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

Thank you for your time!
APPENDIX B.

Raw data.
Table 2 below provides the raw data and the percentages obtained from the questionnaires. The data is divided into service user responses (SU), family member responses (F), and then the combined responses (TOTAL).

Table 2. Raw data from the questionnaires.

<table>
<thead>
<tr>
<th>QUESTION AND RESPONSE</th>
<th>NUMBERS</th>
<th>PERCENTAGES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SU</td>
<td>F</td>
</tr>
<tr>
<td><strong>Qu1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ward staff</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Family Clinic Team</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Ward round</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Other (family member)</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>I don't know</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Community Staff</td>
<td>0</td>
<td>0</td>
</tr>
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APPENDIX C.

Evidence of SRRP feedback.
Dear Bertha,

Thank you for taking the time during your placement here to complete several presentations:

- Your literature review on staff attitudes towards Borderline Personality Disorder to the CMHT staff
- Your teaching on psychosis to a Tamil community
- Your Service-Related Research Project to the Family Clinic team and to the Ward Managers
- Your teaching on working with Borderline Personality Disorder in a CMHT context to CMHT staff

Yours sincerely,

Nicolette de Villiers
Highly Specialist Clinical Psychologist
West Battersea CMHT
AN INTERPRETATIVE
PHENOMENOLOGICAL ANALYSIS ON
THE EXPERIENCE OF PARENTING AND
BEING PARENTED FOR MOTHERS
DIAGNOSED WITH BORDERLINE
PERSONALITY DISORDER

MAJOR RESEARCH PROJECT

JULY 2013

YEAR III
1. ABSTRACT

**Background** Individuals diagnosed with Borderline Personality Disorder (BPD) have not typically had the experience of forming a secure attachment to their caregiver/s. There is a growing body of observational research with mothers diagnosed with BPD, which suggests that mothers with this diagnosis have not developed the skills needed to be a mother. However, there is no published research on the experience of being a mother with this diagnosis and how it may relate to their early experiences of being parented.

**Aims** The present study aimed to explore: (1) The perceptions and experiences of early attachment relationships and current mother-child attachment relationships with mothers with features of BPD; (2) How participants think their relationships with their parents impact on the way they parent their children; (3) What they think are the unique challenges mothers face in relation to the features of BPD; (4) The strategies/resources mothers diagnosed with BPD bring to the tasks of parenting.

**Method** Nine mothers diagnosed with BPD were interviewed. Six interviews were fully transcribed and analysed. The interview schedule included: Their early relationships with caregivers, how they parent their own children, and what has helped them in this role as a mother. The interviews were transcribed verbatim and analysed using Interpretative Phenomenological Analysis.

**Results** Three master themes were derived from the analysis: (1) Early adversity with limited support, (2) Difficulties as a parent with varied support and understanding, and (3) Across the lifespan: patterns in childhood recur in motherhood.

**Discussion** The themes highlighted how maladaptive ways of coping with overwhelming emotions and limited experiences of developing trusting relationships in childhood, made mothering a challenging task. A key aspect of working with this group is the development of a trusting relationship with professionals, to provide mothers with the support they would like in their parenting role.
2. ACKNOWLEDGEMENTS

I would like to thank:

- Each of the mothers who took part in my research, for sharing their incredibly moving and honest stories with me
- Prof. Arlene Vetere and Dr. Stephen Miller for their guidance and supervision during the completion of this research; your support has been invaluable
- The SUN project team, Emergence UK, Rethink, and Sane, for their support in recruitment
“That child has to come first, otherwise you just repeat the same over and over and OVER again and nothing ever changes... You can only reflect what you grow up [with]. I think I KNOW my mum very deliberately went against the way she was raised because her mum showed her no care and no emotion whatsoever. Yes, there were elements of that with my mother, but she was better than her mother, and there are elements of that with me, but I’m better, again, than how my mother was, and if I can send that down to [son] then it changes. If I kept it in the same way it condemns another generation to feeling like hell and that’s not fair.”

(Patricia⁶; a mother diagnosed with Borderline Personality Disorder)

⁶ Pseudonym.
3. POSITION STATEMENT

Growing up in a time when child abuse has been high on health agendas, I became curious about the circumstances in which child abuse can occur. There is often an identified “victim” and “perpetrator” in child abuse cases. I wondered about scenarios when the “perpetrator” had also been a “victim” in their own childhood. Why are some poor parenting practices continued?

My interest in the psychiatric diagnosis of Borderline Personality Disorder (BPD) developed from my pre-training experience of working with individuals diagnosed with BPD, as inpatients and in the community. I noticed that a number of women I worked with stated that they did not want to have children as they did not think they would be able to parent adequately given their own early experiences of adverse parenting. Yet others felt they would be a better parent as they could correct the poor aspects of parenting they had experienced as a child.

During my time in mental health, I have been most struck by mental health clinicians’ negative attitudes towards this group; seemingly unable to understand their current difficulties in the context of their early experiences. Thus, I became interested in qualitative research with this group; offering them a space to facilitate professional understanding of why they present with the difficulties they have. Collectively, this led to my interest in the parenting experiences of individuals diagnosed with BPD; how do their early experiences link to how they parent?

While there are a number of theoretical orientations that attempt to understand the features associated with BPD, I have primarily drawn on the systemic literature, partly due to my own personal preference in understanding an individual in the context of a system. Furthermore, as the research focuses on transgenerational attachment, a systemic orientation seemed most relevant.
4. RESEARCH AND THEORETICAL BACKGROUND

4.1 How is Borderline Personality Disorder defined?

The psychiatric diagnosis of Borderline Personality Disorder (BPD) has been constructed within the dominant medical model; belonging to the overarching category of “personality disorder”. This describes a group of individuals who have long-standing patterns of emotions, thoughts and behaviours that deviate from societal and cultural expectations. These patterns are framed as maladaptive; interfering with one’s ability to function across contexts.

An individual is diagnosed with BPD based on meeting five of nine diagnostic criteria (see Appendix A). However, their difficulties in building and maintaining relationships, regulating emotions, and subsequent maladaptive coping strategies, (used to self-sooth or numb unbearable feelings; Katfsakou, Marougka, Barnicot, Savill, White, Lockwood & Priebe, 2012) are usually the focus of treatment by mental health services. While it is not a formal part of the diagnostic criteria, someone diagnosed with BPD has often experienced early adversity (Spatz Widom, Czaja, & Paris, 2009). They are experienced by mental health professionals as difficult to manage, aggressive and chaotic (Newton-Howes, Weaver & Tyrer, 2008).

Individuals diagnosed with BPD have historically been excluded from mental health services, deemed as “untreatable” (National Institute of Mental Health England [NIMHE], 2003). However, published guidelines have identified that individuals diagnosed with a type of personality disorder should be offered treatment by mental health teams (NIMHE, 2003; National Institute for Health and Clinical Excellence [NICE], 2009). Subsequently there has been a surge of interest in research with people diagnosed with BPD.
4.2 Critique of the diagnosis

The BPD diagnosis has largely been criticised for its validity due to high rates of co-morbidity with other diagnoses, including anxiety disorders, mood disorders, and eating disorders (Zanarini, Frankenburg, Dubo, Sickel, Trikha. Levin & Reynolds, 1998). The diagnosis may actually describe features in individuals who have experienced early adversity, resulting in complex mental health needs. Furthermore, “personality” is defined by a set of features determined on a trait basis; stable across the life span and present in most contexts. However, with the exception of impulsivity and interpersonal instability, the other features of BPD are subject to change across time and context (Tyrer, 2009), suggesting the features associated with BPD are not indicative of a “personality disorder”.

Despite criticism, the diagnosis of BPD is still used as a term for individuals who frequently present to mental health services with difficulties in interpersonal relationships and regulating their own emotions. Clinical psychologists (among other clinicians) have begun to criticise the medical model of diagnostic categorisation, instead favouring a formulation approach to conceptualise individuals who present with mental health difficulties (Harper, 2013; Bentall, 2009; British Psychological Society, 2011). Formulation focuses on the use of psychological theories to facilitate an understanding of what has led to a person’s current difficulties and what might maintain them; hence it focuses on understanding and explanation rather than description. As an alternative to the medical model of BPD, theories perceived to be relevant to the understanding of mothers diagnosed with BPD will be discussed, focusing on attachment, developmental trauma, understanding intergenerational systems, and theories of care-giving. Finally, research literature relevant to mothers diagnosed with BPD will be summarised.
4.3 Lifespan approach to attachment and trauma

4.31 Attachment Theory

Attachment theory was first proposed by John Bowlby (1969) to provide a developmental understanding of emotion regulation in the context of a family system. This primarily focused on the bond between an infant and their primary caregiver (usually the mother). Bowlby outlined that the behaviours exhibited by infants, such as proximity seeking, stimulate care-giving behaviours in adults. Through attachment relationships the infant learns how to understand and predict their environment, and learns survival-promoting behaviours. The caregiver needs to be flexible, responsive, accessible, and predictable enough to provide "good enough" care, in order for the child to build trust and identify the caregiver as a secure base. When the caregiver is established as a secure base a child is able to explore the environment with the security that the caregiver is available, if needed, indicating the child has a "secure" attachment to their caregiver. These experiences are then internalised by the infant as an internal working model of relationships. This determines whether the infant feels they are deserving of care, whether others are deserving of care, and whether others can be trusted. The internal working model is then used, in part, as a template for adult relationships.

Based on Bowlby's theory, Ainsworth and colleagues (1978) developed a tool which aimed to elicit attachment styles and behaviours in a mother-infant observation (see appendix B for an outline and a brief critique). This led to the identification of three attachment styles, with a fourth type added later (Main & Solomon, 1986). The secure attachment, as described previously, refers to an infant making effective use of their secure base, able to explore in the comfort that their caregiver is a safe place to return to. These infants would be distressed by a
caregiver’s departure and comforted by their return. Alternatively, an avoidant attachment is seen when an infant has learned not to turn to the caregiver when fearful, therefore the caregiver is not a secure base. They will show low levels of anxiety during separation from a caregiver, seemingly self-reliant. In contrast to the avoidant attachment style, the anxious-ambivalent style shows an infant who will seek reassurance when fearful. However, as their needs are adequately met by the caregiver and they do not feel reassured; their anxiety and emotional expression can escalate to elicit caregiving behaviour. The disorganised attachment style (Main & Solomon, 1986) was added to understand infants who view their caregiver as a source of both fear and reassurance. Subsequently, these infants are observed as disorientated, “freezing”, showing “contradictory” behaviours, and apprehension towards the caregiver. The other insecure attachment styles are perceived as organised as they are helpful in eliciting desirable responses from caregivers, by high or low emotional expression. The disorganised attachment style, however, does not help the infant to survive in their environment, as the caregiving behaviour is intermittent. The infant learns that they cannot predict the caregiver response, regardless of their behavioural strategies. This is often seen in infants who are exposed to severe childhood adversity.

The insecure attachment styles can become maladaptive when later applied to healthy adult relationships; those with insecure working models in infancy typically have poorer romantic attachments as adults (McCarthy & Maughan, 2010). However, as they are “working models”; infants can later go on to develop secure attachments in adulthood despite showing signs of an insecure attachment in infancy, termed “earned security”. Those with earned security have generally accessed emotional
support from another trusted attachment figure (Saunders, Jacobvitz, Zaccagnino, Beverung & Hazen, 2011).

4.32 Dynamic Maturational Model (DMM)

Crittenden’s life-span model focuses on how behavioural strategies evolve in the context of adapting to danger in infancy. When placed in dangerous situations infants develop strategies and behaviours in order to elicit the response desired from others. Crittenden’s model proposes that attachment patterns are not fixed but rather are adaptive to the environment and mature over time (Crittenden, 2006a; Crittenden, 2008). As infants develop and increase their repertoire of social encounters, their strategies also multiply. When attachment strategies do not multiply or adapt to new people or new situations they become maladaptive and less functional in protecting the individual.

Crittenden describes the importance of somatic, cognitive, and affective information in facilitating an individual’s understanding of the situation they are faced with, and subsequent strategy selection. Depending on the balance between these three types of information, a person will have particular “dispositional representations”. Dispositional representations describe how much emphasis one places on each type of information when selecting a behavioural strategy. If the three sources of input provide congruent information, then the individual will proceed with a strategy based on that information. When the information is incongruent, for example, affective information does not correspond with cognition (e.g. a memory of a similar situation); an individual must decide whether to follow the affect or cognition in selecting a behavioural strategy. By deciding too quickly the individual risks making an error in their response, however. Responding too slowly puts the individual in danger.
People with type B dispositional representations have an integrated information-processing ability, responding to both true affect and true cognition that is closely linked to reality. Individuals with a type A dispositional representation are cognition-driven; they focus minimally on affect, thus decreasing emotional arousal. In contrast, individuals with type C dispositional representations are affect-driven, with little focus on cognition and increased emotional arousal. There are multiple levels to each type; depending on how close to reality or how distorted the information perceived is (see Appendix C for a diagram and more detailed summary of the strategies).

As individuals diagnosed with BPD show high emotional arousal at baseline and following threat (Linehan, 1993), it is anticipated they use type C strategies, with distorted affect information as the primary influence on their behavioural strategy. For example, increased affect in interpersonal situations, due to early caregiver experiences, may lead to verbal or physical aggression towards others.

4.33 Developmental Trauma

Historically, the child attachment literature, adult attachment literature, and the trauma literature were developed separately. Similar to Crittenden’s model, van der Kolk (1996) and Hermann (1992) have attempted to integrate these three literatures into a life-span model, in order to understand the long-term effects for individuals who have experienced childhood interpersonal trauma. Van der Kolk (1996) and Herman (1992) have proposed the categories: Developmental Trauma Disorder and Complex PTSD (see Appendix D for diagnostic criteria). These diagnostic categories help to explain the experiences of those exposed to on-going early adversity that is not currently captured by other diagnoses, including BPD.
Unsurprisingly, individuals who are exposed to repeated childhood adversity, as opposed to a one-off traumatic event, are more likely to present with complex symptoms (D’Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012). Similarly, those who are exposed to trauma of an interpersonal nature also show greater symptom complexity (van der Kolk, 2005a). Subsequently, repeated interpersonal trauma in the earlier years of an individual’s life can have a profound effect on the person’s psychological development, i.e. personality (van der Kolk, 1996). Van der Kolk (1996) identifies how a secure attachment style can protect an individual from the repercussions of adverse experiences that could lead to a trauma response. However, for infants where the parent is the source of fear/abuse, a child maintains a state of chronic hyper-arousal, as the environment is never safe enough to reduce their vigilance (Herman, 1992). The infant is further at risk of symptom complexity if the trauma has occurred in the absence of other resilience-promoting factors, for example, a supportive network.

As highlighted, van der Kolk (1996) describes the complex symptomatology found in individuals who have experienced early adversity, i.e. who are chronically hyper-aroused. They are prone to difficulties with: (1) a sense of self, (2) affect and impulse control, (3) a sense of responsibility (usually self-blame to maintain positive view of primary caregiver), (4) interpersonal relationships, (5) reflective function. In relationships, they may fluctuate between a state of care-seeking from an abusive/neglectful caregiver, as part of an evolutionary response to seek care and proximity (Bowlby, 1969), to a state of social withdrawal, perceiving relationships as unrewarding and dangerous. Difficulties with reflective function develop as a defence against the contemplation of adverse experiences in-depth, as this could be

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7 Reflective function is an ability to think about and learn from past experiences.
too frightening or painful. For example, perceiving a caregiver as wanting to harm them, for example, “my mummy wants to hurt me”.

As infants have not had the opportunity to develop the aforementioned capacities, they are likely to grow up experiencing re-traumatisation (van der Kolk, 1989), by re-enacting the trauma with others, as a victim or perpetrator. Individuals who have been traumatised also employ self-damaging coping strategies to (1) self-soothe and numb the experiences of intense emotions, e.g. alcohol use, (2) to “feel alive” when one feels numb, e.g. cutting. Individuals who have been traumatised may oscillate between the two states of numbness and hyper-arousal, finding it difficult to find an affective equilibrium (Horowitz, 1976), thus they develop self-damaging coping strategies to regulate emotions.

Van der Kolk’s description coincides with someone who would be given a diagnosis of BPD, but with a contextual understanding of why these difficulties may occur. Similar to the attachment models, the developmental trauma literature provides a life-span understanding of those diagnosed with BPD.

4.34 Intergenerational patterns in systems

Theory and research repeatedly suggests that the development of affect regulation is learned through interactions with caregivers (e.g. Schore, 2001) and is linked to maternal sensitivity (e.g. Kogan & Carter, 1996). This could suggest an intergenerational transmission of difficulties with affect regulation. How can mothers teach their infants to regulate their affect if mothers are unable to regulate their own? Byng-Hall (1985) proposed the idea of “family scripts” from intergenerational family therapy sessions. This concept suggests that individuals build up and store sequences of memories related to particular events. When each member of a family unit holds a particular sequence as a script, it becomes known as a “family script” (Byng-Hall,
Family scripts enable an individual to decide upon an action in a given situation without too much process, hence it saves energy for individuals to focus on novel situations.

When new generations adopt the same role as their parents it is deemed a "replicative script"; when individuals repeat the same patterns of care-giving and care-seeking they experienced in their own early relationships. Alternatively, new generations can choose to correct the errors their parents made, thus developing a corrective script (Byng-Hall, 1985). As each individual brings to a new relationship their own family scripts this will result in a blend of family scripts from the two individuals, thus resulting in both replicative and corrective scripts. The number of replicative scripts will depend on the concordance between the family scripts and the belief systems of the two individuals.

Linking the concept of family scripts to early adverse experiences and affect regulation, research evidence suggests that adverse early experiences are repeated across generations, whereby those who have been exposed to early traumatic events can experience a "compulsion to repeat", including re-enacting the trauma they experienced as the perpetrator rather than the victim (van der Kolk, 1989). Studies investigating attachment styles of mothers and their children have found correspondence between the two (van IJzendoorn, 1995), suggesting an intergenerational transmission of attachment style, potentially related to replicative family scripts. Linking back to Bowlby and Crittenden's models, those exposed to early adversity typically have limited, maladaptive strategies to manage novel interpersonal situations, due to their own early attachment relationships. This will inevitably limit the strategies an individual has in the mother-infant relationship, potentially leading them to rely on replicative family scripts. This puts mothers
diagnosed with BPD at risk of repeating their own early adverse experiences. Furthermore, as attachment and emotion regulation is developed in the context of a family (Bowlby, 1969), it is possible that attachment style, and subsequently emotion regulation, will also transmit across generations.

There are, however, instances where this is not necessarily the case; known as the “transmission gap”. A significant finding linked to transmission of attachment style is the concept of maternal reflective function; a mother’s ability to consider her own and her infant’s behaviours in the context of internal states, specifically cognition and affect. Maternal reflective function has been found to predict infant attachment security to a higher degree than a mother’s own attachment style (Fonagy & Target, 2005). Research also suggests that social support and life stressors can also influence adult attachment styles (Sroufe, Egeland, Carlson & Collins, 2005).

4.4 Theories of parenting/caregiving

While there are a growing number of treatments for individuals diagnosed with BPD (e.g. Linehan, 1993; Bateman & Fonagy, 2004), there are no identified theories related to BPD and parenting. Theories of parenting in the context of early adversity and poor attachment relationships, however, have been put forward to identify what leads to the development of different parenting styles.

4.41 Adult attachment style and care-giving

Drawing on the attachment literature, George (1996) suggests that internal working models developed in childhood influence parenting styles. Parents who have a secure attachment style provide a secure base for their children, allowing them to explore the environment, and comforting them when they feel unsafe. They are flexible in their care-giving behaviour, suggesting multiple strategies in managing relationships (George & Solomon, 1996).
Howe, Brandon, Hinings & Schofield (1999) apply adult attachment styles to parents who maltreat their children. They identify that carers who go on to be physically abusive towards their children are likely to have a dismissing attachment style, with low emotional expression. The punitive parenting they received as a child is perceived to be an appropriate form of care for their own children. With high expectations of their children, they provide low support and interact minimally with their children.

In contrast, neglecting caregiving is formulated around a helpless internal working model, based on a passive and ambivalent attachment style. The carer is likely to have high dependency on others but a low ability to cope, providing an unstimulating environment for their children.

Finally, the abusing and neglecting caregiving style reflects an unresolved attachment in parents. This is identified as related to the caregiver’s own experiences of early unresolved trauma or mental health difficulties. Their internal working model is based on control and rejection (mirroring their caregiver’s style), with the combined fear of being rejected by the child. They may subsequently perceive the child as threatening. They can fluctuate between non-responsive and punitive, feeling out of control both in relation to the self and their children. Caregivers might be reminded of their own early experiences of care-seeking in their role as a parent, which may limit how able they are to provide care to another.

4.42 Crittenden’s approach to parenting

Based on the Dynamic Maturational Model (DMM), Crittenden identified the protective strategies that parents may adopt that can lead to maltreatment of children (Crittenden, 2006b; Crittenden, 2008). Crittenden identified distortions that influence parenting depending on how close to reality one’s perceptual information is, as
described in the DMM section of this review. Depending on the level of distortion the parent will vary in how much emphasis they place on protecting the self versus protecting the child. She identified three parenting styles that linked into type A dispositional representations; with an emphasis on cognitive information in processing danger. A further three parenting styles were linked to the type C dispositional representations; where the emphasis is on affective information in processing danger. Individuals with a diagnosis of BPD are defined by their difficulties in emotion regulation (APA, 2013) and show elevated levels of emotional arousal at baseline, and steeper levels of emotional arousal following a stressor (Linehan, 1993). As Type C parenting styles relate to parents who are heavily influenced by affective information, these were selected as part of the review. Appendix E contains a summary table of each of the types of parenting and the impact on the child.

4.421 Distortions of normal child-protection behaviours

Parents may overlook the probability of danger, therefore they will under-protect, and in some instances neglect, their children. Parents may not respond in a timely fashion to their children’s needs. While they will soothe and comfort their children, it will be at a point where the child’s arousal has heightened.

4.422 Distortions that emphasise self-protective behaviour

Parents may over-estimate the danger to themselves at the expense of protecting their children, leading to psychological neglect of their children. Parents will focus on their own need for comfort, possibly linked to unresolved past trauma or involvement in current adult relationships that creates risk, such as domestic violence. Due to the parent’s focus on themselves and their own needs, they will focus less on the children, experiencing periods of “psychological absence”. While
the parent might try to protect the child from knowing about their past/current trauma, this prevents the child from understanding their parent’s behaviour. Parents may position themselves as child-like and vulnerable and view the child as powerful.

4.423 Distortions that substitute delusional information for accurate information

Crittenden (2008) identifies that parents within this category may have more severe psychiatric diagnoses, including schizophrenia, bipolar disorder, psychotic disorder and BPD. Parents may perceive the child to be the source of threat, and themselves as under threat from the child. This leads to the attack, abandonment or, in extreme cases, murder of the child (Crittenden, 2008). Parents in this category may also sexually abuse their child, leading to a sense of shame. To relieve the shame, they may feel a need to “destroy” the child. Alternatively, some parents murder their children to save them from a lifetime of misery, based on their own perception of existence as miserable. An important consideration in this category is the perceived or real isolation of the mother; this enhances her perception of herself as vulnerable.

Although not directly based on mothers diagnosed with BPD, the approaches to parenting presented provide a useful framework for understanding some of the challenges mothers with a diagnosis of BPD may face. Firstly, the mother who has features of BPD is less likely to have reached a stage of psychological “maturity”, due to her own early adverse experiences, for example, reduced ability in reflective function or affect regulation. This makes her more susceptible to attributing all-encompassing labels and intentionality to her children, based on her own schemata that “others are bad and cannot be trusted”. Finally, the support of a trusted personal and professional network is inevitably a challenge for individuals who have had little
experience of a trusting relationship growing up. As a result, mothers diagnosed with BPD are more likely to be isolated. Thus, they are less likely to give their children opportunities of interacting with adults with well-developed skills in reflective function or affect regulation.

4.5 Previous quantitative research

A literature search\(^8\) revealed eight quantitative studies had been conducted with mothers diagnosed with BPD and their children. See appendix F for a tabular summary of the quantitative research in this field.

When focusing on infants, research shows there are early signs of potential attachment difficulties in the relationship. For example, infants of mothers diagnosed with BPD were more likely to look away from mothers during gazing and showed lowered affect (Crandell, Patrick & Hobson, 2003). They were also less responsive to their mothers and less willing to engage with their mothers (Newman, Stevenson, Bergman & Boyce, 2007). Feldman, Zelkowitz, Weiss, Vogel, Heyman & Paris (1995) found that children of mothers diagnosed with BPD were more likely to be exposed to adverse events, such as parental suicide attempts. Studies have also found that children are more likely to seek “excessive reassurance” and show signs of an insecure attachment (Abela, Skitch, Auerbach & Adams, 2005). Furthermore, their narratives show more fear of abandonment, parent-child role reversal, and negative relationship expectations (Macfie & Swann, 2009). When focusing on the mother in the interaction, research also highlights that mothers with this diagnosis find developing a relationship with their infant difficult. They are described as “insensitive” towards their infants (Hobson, Patrick, Crandell, Garcia-

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\(^8\) The search included a number of databases, including: PSYCHinfo, Medline, Psychology & Behavioural Sciences Collection, PubMed, SAGE Premier. Terms included “borderline personality disorder” or “personality disorder” or “borderline” or “BPD” AND “parent” or “parenting” or “parental” or “maternal” or “mother”.
Pérez, & Lee, 2005; Newman et al., 2007) and show “disrupted affective communication” (Hobson, Patrick, Hobson, Crandell. Bronfman & Lyons-Ruth, 2009). Interestingly, mothers diagnosed with BPD also self-report feeling less satisfied, less competent and more distressed in their parenting role (Newman et al., 2007), indicating they are aware they have difficulties in building a relationship with their children. Research has also found that parents with children in care have higher levels of BPD features (Perepletchikova, Ansell & Axelrod, 2012).

4.6 Previous qualitative research

Individuals with the diagnosis or features of BPD have been the focus of a number of qualitative studies in recent years, as interest in the diagnosis has increased. Research has largely focused on the experience of having the diagnosis and the difficulties associated with it (e.g., Dammann, Hügli, Selinger, Gremaud-Heitz, Sollberger, Wiesbeck, Walter, 2011; Adams & Sanders, 2011; Holm & Severinsson, 2011; Walker, 2009).

With professionals striving to understand a group of individuals who have received poor services and negative attitudes from staff in mental health services in the past (e.g. Deans & Meocevic, 2006; Markham, 2003; James & Cowman, 2007), there has been an increase in the qualitative enquiries into the treatment/care experiences of individuals diagnosed with BPD (e.g., Rogers & Acton, 2012; Hodgetts, Wright & Gough, 2007; Langley & Klopper, 2005).

To date, only two published qualitative papers have focused specifically on traumatic childhood experiences of women diagnosed with BPD, and how it affects them as adults. The first paper found one main theme: “longing for reconciliation”, whereby women searched for the meaning of their childhood experiences. Two secondary themes focused on “living with a sense of shame and guilt” and
“struggling to be released from a sense of being trapped” (Holm, Berg & Severinsson, 2009).

The second paper found two main themes, with an emphasis on resilience and survival. The theme “power” focused on surviving “being forced and assuming responsibility”. The second theme, “assessment of vulnerability”, focused on “surviving victimisation and not feeling loved” (Holm, Bégat & Severinsson, 2009).

The research team highlighted that women with BPD face a number of early traumatic experiences in relation to their parents, providing additional support for the quantitative literature, that the parenting experiences for individuals diagnosed with BPD is a significant area which warrants further, focused research.

4.7 Summary of research and theoretical literature

To summarise, literature on attachment (Bowlby, 1969; Crittenden, 2006) and chronic developmental trauma (van der Kolk, 1992) has suggested that infants and children exposed to early adversity have difficulties in developing affect regulation, reflective function, and forming/maintaining interpersonal relationships, in adulthood. This literature allows for a lifespan perspective on early adversity and trauma. While research on earned security suggests some individuals exposed to early adversity can develop secure attachments in adulthood, this is largely dependent on a supportive network. For individuals with interpersonal difficulties, who have difficulties developing trusting relationships, this is unlikely to be available. As this group will usually have difficulties in relationships as adults, they will most likely have difficulties in their relationships with their children. This is currently supported by the quantitative research literature on mothers diagnosed with BPD.
Similar to the literature by van der Kolk and Herman, the current study attempts to integrate childhood attachment, adult attachment, and trauma, in exploring the life-long effects of the early experiences of women with emotion regulation and interpersonal difficulties as they enter motherhood. This will be understood within a systemic framework; exploring intergenerational patterns of parenting to illuminate how parenting practices may or may not recur across generations.

Quantitative research has illustrated the difficulties mothers with BPD and their children can present with through observation and self-report questionnaires. To date, however, research does not offer any phenomenological understanding of what it is like to be a mother who experiences the difficulties associated with BPD, i.e., emotion dysregulation and a history of poor attachment relationships.

5.8 Research aims

The aim of the research is to explore the phenomenological experience of parenting and being parented, and any perceived links between the two, with mothers who self-identify with the features of BPD. Supporting the research aim, the quantitative literature related to mothers diagnosed with BPD, and clinical literature about parents with a diagnosis of a mental illness (e.g. Göpfert & Webster, 2004; Cowling, 2004; Aldridge & Becker, 2003), frequently refer to the BPD diagnosis as a risk factor for encountering difficulties with parenting. Thus, professionals may preempt that mothers with a diagnosis of BPD have poor parenting skills. Mothers with this diagnosis, however, do acknowledge they have difficulties in parenting their own children (e.g. Newman et al., 2007), but the quantitative literature does not offer any understanding of why. Current research has neglected the service user experience of being a parent for individuals diagnosed with BPD.
Current qualitative research has illuminated the experience of accessing services for individuals diagnosed with BPD. As individuals with features of BPD are better able to access treatment following the NIMHE (2003) publication, there has been a wealth of qualitative research exploring their experiences of accessing mental health services. What is lacking, however, is an understanding of mothers' experiences of accessing services when they have a diagnosis of BPD. What is helpful in terms of managing their experiences as a parent? This can better inform the services this client group accesses, where mothers diagnosed with BPD might need more support.

In order to explore the research aims, a qualitative methodology was selected to gain an in-depth understanding of the lived experiences of mothers with features of BPD to complement and develop the existing quantitative literature. Qualitative literature has grown increasingly popular in healthcare settings (Alasuutari, 2010) as it can be helpful in explaining findings from quantitative research or providing ideas for future quantitative research. Qualitative research focuses on understanding a situation or behaviour (Pope & Mays, 1995), which adds a contextual validity to the findings from quantitative enquiries, thus complementing the quantitative literature.

To date, there is no published research on parenting experiences or interventions received by mothers with a diagnosis of BPD. A qualitative methodology offers this previously marginalised and excluded group the opportunity to partake in research which facilitates a space to have a voice and encourages a sense of empowerment and inclusion (Larkin, Watts & Clifton, 2006). As the research focuses on the lived experiences of a previously excluded population, Interpretative Phenomenological Analysis was selected as most appropriate to enable the research aims to be met.
4.8 Research questions

- To explore the perceptions and experiences of early attachment relationships and current mother-child attachment relationships of mothers with (self-identified) features of BPD.

- To explore how participants think their relationships with their parent's impact on the way they parent their children.

- To explore what they think are the unique challenges mothers face in relation to the features of BPD.

- To explore the strategies/resources mothers with BPD bring to the tasks of parenting.
5. METHOD

5.1 Ethical issues

As a formal means of reviewing the ethical risks of the project, the proposal was formally submitted and reviewed by the City & Hampstead Research Ethics Committee. The panel returned a favourable opinion with conditions which were subsequently met. The University Research Ethics Committee also reviewed the research and gave a favourable opinion for the research to proceed. Amendments made to the project were also reviewed and agreed by the Committee (see Appendix G for ethics paperwork).

To address the potentially distressing nature of the research, it was clearly stated on the information sheet that participants should not take part should they consider the topics of early experiences and/or parenting too distressing to discuss. In order to ensure adequate support after the interview, meetings were scheduled prior to any therapy the participant accessed so the participant could seek support through this medium. If this was not feasible or they were not currently accessing therapy, participants were advised to arrange have some support available after the interview.

5.2 Qualitative method

5.21 IPA rationale

Narrative analysis and thematic analysis were also considered, however, given a larger, homogeneous sample size is desired in thematic analysis; this did not seem feasible for a time-limited project, with a largely heterogeneous group. Although narrative analysis could also be employed, the epistemological underpinnings of IPA, specifically the emphasis on double hermeneutics, were perceived to be more important in conducting this project.
Interpretative Phenomenological Analysis (IPA) (Smith, Flowers & Larkin, 2009) was selected as most suitable to address the research aims. There are three core concepts that underpin IPA; phenomenology, hermeneutics, and idiography, that were important in addressing the research questions.

Phenomenology focuses on the study of experience; exploring how individuals come to understand their experiences of the world, in this instance in the context of being a mother diagnosed with BPD. It aims to focus on the expression of experience in the individual’s terms rather than applying experiences to predetermined category systems, described in previous quantitative research with this group. This allows the individual’s lived experience to remain the focus of the research. Phenomenology is of importance to psychologists in considering a person’s understanding of their experience as it is crucial to both developing theory and clinical practice, particularly with a stigmatised and misunderstood group.

In using phenomenology, the researcher is able to understand a person’s unique perspective on the lived experience, while also reflecting on the understanding that their own interpretation impacts on how they hear the person’s experience, known as a “double hermeneutic”. Hermeneutics is a theory of interpretation. When engaging in the analysis using IPA, the researcher is “making sense of the participant, who is making sense of x” (pg. 35; Smith, Flowers & Larkin, 2009). Hence, when using IPA it is important to be aware of one’s own background and biases to reflect on how this might influence the analysis. This is of particular importance in the current research whereby the researcher had worked with this client group for several years.

The final concept, idiography, relates to the particular. Quantitative research and diagnosis in mental health focuses on a nomothetic approach, in conceptualising
a group who share a commonality. Idiography focuses on understanding the individual, thus an emphasis on the detail. An idiographic approach enables a unique perspective on a particular phenomenon, which cannot be generalised but instead illuminates and enriches knowledge on that phenomenon. This is of particular significance for such a heterogeneous group of individuals, whereby, two individuals diagnosed with BPD can present very differently.

5.22 Trustworthiness

Qualitative methodology has been identified as too subjective as, unlike quantitative research, it is not assessed on “objective” concepts such as validity and reliability (Shenton, 2004). Subsequently, a number of tools and guidelines have been developed to ensure the trustworthiness of qualitative research.

Shenton’s guidelines were followed (2004; see paper for a full review), outlining four concepts that increase the trustworthiness of qualitative research; credibility, transferability, confirmability, and dependability. Processes were put in place during the research data collection, analysis and write-up, to ensure the project was trustworthy.

Firstly, regular supervision was sought from two supervisors with knowledge and experience of working with adults, including mothers, who have experienced adverse early experiences. Supervision was used throughout the research process, particularly during the development of the themes in the analysis stage.

Secondly, a reflective diary was kept during the research process to record thoughts and feelings regarding the research. This was used to monitor any particular aspects of the research the researcher may be attending to, allowing these to be noted and “bracketed off” (Smith, 2009), so other important information can be more easily heard. This was a key part of the interview and analysis process.
As the researcher was a White British woman in her late-twenties raised in the UK, demographically there were some similarities to the women interviewed. However, there were many differences, demographically, in terms of early experiences, and, experiences of parenting. Given the researcher had also worked with this client group historically, it was important to monitor any pre-conceived ideas about this group.

When the data analysis was completed, a focus group was held with the original recruitment site team, the Service User Network (SUN) project, to feed back the results from the data analysis to gain their views on how results relate to their experiences of working clinically with this group. The meeting is summarised in the Results section.

Unfortunately, the final three interviews were completed at a later stage in the analysis due to recruitment difficulties (please see limitations section in Discussion). As the timescale did not allow for full transcription and analysis of these interviews they were used to assess for data saturation based on the identified themes. A “top-down” analysis was applied to the final three interviews to check whether the same themes emerged. This is discussed in the Results.

To illustrate openness, an “audit trail” of the process from data to master themes was developed in a tabular form as part of this project, frequently linking the themes back to the data.

Finally, the Critical Appraisal Skills Programme (CASP) tool for qualitative research (Milton Keynes Primary Care Trust. Available at http://www.phru.nhs.uk/casp/qualitat.htm), designed to critically appraise research, was applied to the project to assess for openness and trustworthiness.
5.3 Sampling method

A purposive sampling method was employed, recruiting via various forums across the UK. The first service used to recruit individuals was the Service User Network (SUN) project; a group peer support service which helps people cope with “personality disorder and emotional/behavioural difficulties”. The researcher attended support groups and offered a brief introduction to the research. Group members were offered information sheets (see appendix H) with contact information if they wished to take part. As there were significant difficulties recruiting a sufficient number of participants, other personality disorder services were approached. Staff in these services offered individuals who met the inclusion criteria an information sheet. Finally, several charities (Sane, Rethink, and Emergence UK) were approached to advertise the project on their websites (see Appendix I). While the project initially aimed to recruit those who self-identified with the diagnosis, those who enquired about the study all had a formal diagnosis of BPD, as well as identifying with the diagnosis.

5.4 Development of the interview schedule

An interview guide was developed for the purpose of the project (see Appendix J). The interview guide was derived from the research aims to ensure the aims of the project were met. The interview guide was discussed with two supervisors. This process enabled the development of several prompting questions. The interview focused on four main areas:

- The participant's early relationship with their parents,
- The participant's current relationship with their own child/ren
- How the features of BPD impacts on the way they parent
- What resources the participant makes use of in relation to parenting
This interview was piloted with two trainee clinical psychologists who had experience of working with this client group. Following the pilot interviews, the interview schedule was discussed again in supervision and adjusted accordingly. Although the interview guide was available, participants were able to direct the interview, based on what they felt was important.

5.5 Participants

Nine mothers were recruited to the study. Please see Appendix K for a tabular summary of each participant, including demographics and the early and current home environment. The mothers were aged between 20 and 65. All but one mother had received their BPD diagnosis after having children. Six participants were White British, two were Black British, and one was White Other. Five mothers had one child (Range: 1-3 children).

5.6 Data collection

All interviews were held face-to-face either on an NHS site or in the participant’s home. Interviews commenced with the participant confirming they had read the information sheet and signing the consent form (see Appendix L). The interviews lasted a maximum of two hours, using the interview guide detailed in appendix J. Six interviews were transcribed verbatim by the researcher.

5.7 Analysis

The transcripts derived from the interview data were analysed using Interpretative Phenomenological Analysis (IPA), using Smith’s (2009) book as a guide. Prior to beginning formal analysis of the data, notes were made prior to and after the interviews to “bracket off” any pre-conceptions about the individual and/or interview (Smith, 2009).
The initial step involves familiarising one’s self with the data, by transcribing and then reading through the transcript several times. Initial notes are made regarding anything of interest in the data. Next, comments were added related to: (1) descriptive; what the participant had said, (2) linguistic; language used by the participant, (3) conceptual; interpretative comments, including questions raised during analysis (see Appendix M for transcript annotation). Initial comments were mapped based on inter-related ideas and patterns to reduce the quantity and detail. The process of mapping inter-related ideas was repeated in order to generate themes across the transcript. Extracts from the transcript were allocated to the themes to ensure the themes identified were driven by the data. Finally, the themes for each transcript were looked at collectively to identify patterns across participants, to help define and organise the super-ordinate themes.
6. RESULTS

6.1 Overview

Themes are presented in Table 1. See Appendix N for a table of themes, demonstrating the process from data to master theme.

Table 1. Summary of the themes generated from the transcript analysis.

<table>
<thead>
<tr>
<th>Early adversity with limited support</th>
<th>Difficulties as a parent with varied support and understanding</th>
<th>Across the lifespan: patterns in childhood recur in motherhood</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Signs of anxiety/depression in childhood due to early adverse experiences</td>
<td>4. I love my children but it is difficult to be a parent to them</td>
<td>7. I find alternative ways of coping when support from services isn’t available or helpful</td>
</tr>
<tr>
<td>2. “I’m like a square with circles”: Feeling different and a disappointment to others</td>
<td>5. Feeling uncertain about parenting skills leads me to seek support and feedback from others</td>
<td>8. I was taught to keep feelings inside... but it leads to outbursts and violence</td>
</tr>
<tr>
<td>3. My parents didn’t support me growing up but sometimes I found alternative support</td>
<td>6. Children don’t understand my mental health problems</td>
<td>9. Sometimes my children end up in similar situations to what I experienced but I try to do things differently to my parents</td>
</tr>
</tbody>
</table>

The first master theme was a cluster of themes relating to participants’ early experiences of adversity in the context of limited social support at home and in other settings. The second master theme focused on motherhood; the challenge of managing depression while being a mother, feeling overwhelmed by motherhood, and seeking support and understanding from others. Finally, the third master theme captured patterns from childhood, which were mirrored in adulthood. This included maladaptive ways of managing overwhelming negative emotions through self-damaging behaviours or aggression towards others. There were also descriptions of replicative and corrective family scripts. Participants tried to parent differently to their own caregivers, but sometimes their children still faced early adversity.
6.2 Early adversity with limited support

This master theme is a cluster of themes related to the participants’ early experiences, capturing the isolation they experienced across contexts, including in the family home. Participants described home environments where they did not feel either safe, loved, or accepted by their parents.

6.21 Theme one: Signs of anxiety/depression in childhood due to early adverse experiences

The first theme identified the dilemma participants experienced in understanding why they now had difficulties with emotions and relationships. While most participants acknowledged that their current difficulties linked to their environmental experiences, some also wondered about the role of genetics/biology.

“[Other people with BPD] have a reason... Horrendous things have happened to them... Where’s my excuse?... I think my brain was wired wrong” (Jasmine)

Fitting with the developmental trauma literature (van der Kolk, 1989), participants generally linked the start of their anxiety and/or low mood to significant interpersonal events in childhood; commonly related to abuse, bullying and neglect/isolation. Leyla, Sienna and Katie all experienced sexual abuse pre-adolescence, in a context where they had no support network to turn to. The women spoke about normalising the abuse/violence growing up, as there appeared to be little opportunity to hear alternative perspectives to that of the abuser (Graham, 1994).

“[I was] quite lonely... When I was eleven I worked at a [work place] and the owner of the [work place] was forty-six and I had a sexual relationship with him from eleven to sixteen... Psychiatrists and stuff say that’s sexual abuse but I don’t
see it that way because it’s something I wanted to do... I was quite detached from the family” (Katie)

Sienna, Stacey and Katherine described growing up in fearful and unpredictable environments, where they were exposed to domestic violence and threats of abandonment.

“It was like world war three with my mum and dad; they were always rowing and fighting... My dad would leave home and then come back again... My mum always kept saying she was gonna run away and leave me- and that was my biggest fear” (Katherine)

For Jasmine, Hayley and Patricia (with Sienna describing a mix of the two), rather than growing up in chaotic and disruptive environments, they grew up in environments where there appeared to be high levels of perfectionism and expectation. The immense pressure from their parents appeared to lead to elevated levels of anxiety.

“So I just plunged into being educated, because my mum’s very education-focused, I wanted her to love me so I just plunged into trying to get a career...” (Sienna)

As participants wondered what had led to their early experiences they also reflected on their own mothers’ mental health, and highlighted signs of emotion regulation difficulties or depressive symptoms. This enabled them to understand somewhat why their mothers had parented them in the way they did. Katie identified that she felt her mother showed signs of BPD.

“The more I’ve learned about borderline personality disorder the more I think that my mum had it... her mood changes and switches... she’s definitely got issues” (Katie)
6.22 Theme two: “I’m like a square with circles”: Feeling different and a
disappointment to others

The second theme related to a sense of difference and isolation that the clients
experienced growing up; never feeling as though they belonged or were accepted
anywhere. “I’m like a square with circles” refers to Jasmine’s experience of not
fitting in with her family as they were too “functional” and “normal”, which left a
sense of loneliness and isolation. Leyla spoke about being sent to live with various
relatives during childhood/adolescence, leaving her with a feeling that she was “not
good enough”.

The sense of difference and disappointment was exacerbated by perceived
preferential treatment of siblings; for example, Patricia described her younger sisters
as being “cosseted; everything was done for them”, whereas she was expected to be
independent. However, it was not always necessarily just the participant who was
rejected by the mother; Katherine and Sienna both described how they and other
siblings were rejected by the mother, with another sibling being the favoured child.

“The little one, the baby, has been the apple of my mum’s eye. The three
older girls got pushed out quite a bit” (Katherine)

“Speaking with my sister, she kind of feels that my mum doesn’t love her... so
I don’t know if there’s a connection about girls... even in adulthood [brother] can do
all sorts of things to her and she always accepts him back. With me and my sister, it’s
like she punishes us... We have to grovel” (Sienna)

Another significant interpersonal event for participants during
childhood/adolescence was not being accepted by their peer group. They not only felt
rejected and/or neglected at home, but had a similar experience when they went to
school, where they felt ridiculed, excluded or felt “different” to their peers:
“I found it hard to make friends- I dunno whether I think I must have isolated myself because I felt different” (Stacey)

“I felt really different at school to all the others... I was way ahead... I felt different to all my friends because of the experiences I was having... I felt like at school, I felt that if I answered questions I'd be seen as a no-it-all so I couldn't really be myself... I didn't really have friends” (Katie)

6.23 Theme three: My parents didn’t support me growing up but sometimes I could find alternative support

A common experience shared by each participant was the lack of support they felt they received from their parents. Fathers were mentioned less often and seemed to be less available to participants, whereas Mothers were explicitly referred to as unsupportive and emotionally distant. The participants’ understanding of this varied; some understood it to be a reflection of how their own mothers were raised, or the impact of mental health difficulties (as detailed in the first theme). Participants sensed they could not turn to their mother in times of need, usually in the context of domestic violence (Stacey & Sienna), work commitments (Charlotte & Patricia) or an intentional emotional distance put in place by their mothers (Katherine, Hayley, Leyla, Patricia, Katie).

Sienna described spending weekends alone because her mother was working; but when her mother was at home, she remained emotionally and physically distant.

“My mum wouldn't do much with me... She wasn't that kind of person to sit down and talk and cuddle... We never sat down and ate together... I just wanted acknowledgement from [mother] that she cared” (Sienna)
Stacey described her mother as very supportive; however, in the context of domestic violence her mother was unable to support her when she told others about the abuse at home due to fear of her new husband.

"My mother knew he hit me but my mother was too afraid of him" (Stacey)

Leyla spoke about turning down a place in an art college in order to seek her mother’s approval and support, because her mother was more focused on finance than Leyla’s ambitions.

"My mum actually turned around and said there was no reason for me to- what would I be doing with art? That was what she wanted- that’s all she could think of, she didn’t see it as a career, she didn’t understand why I’d wanna do it, so I didn’t take the place" (Leyla)

Hayley described having alternative female support in “surrogate mothers” who she could speak to growing up; although she described only speaking to them “a bit”, reinforcing the difficulty of trust following difficulties in the parent-child relationship. Katie spoke about the challenge of growing up without a female influence. Although she saw her mother, her mother’s alcohol use made it difficult to build a relationship with her.

"I definitely wasn’t happy, and erm it was hard ‘cause my sister wasn’t really around and you haven’t got mum to do normal things with... I found it really difficult, wanting someone to show me how to use make-up and do my hair and things like that” (Katie)

A pattern that emerged in the context of adverse early experiences was the difficulty of not being believed and supported by others when the participants were courageous enough to share with others what had happened to growing up. Disbelief of a child’s experiences teaches the child they cannot trust their own emotional
experiences, suggesting they can no longer rely on their own interpretation of events. Sienna was told by her mother to withdraw her disclosure that her step-father had sexually abused her; otherwise her siblings would go into care. Charlotte commented that she had spent so long identifying school as her main source of support that her teachers’ opinions were more important than her parents. Therefore, when she was bullied at school it was hurtful that teachers did not validate her experiences.

"The teacher shouted- she took me out of the class, shouted at me. All the class inside could hear, and then she told me I was lying and that I was malicious and stuff... all the girls turned against me” (Charlotte)

While alternative support was often adaptive, there was also the risk that seeking alternative support actually made some participants vulnerable to abuse. Another issue was the lack of longevity. Leyla spoke of moving abroad, away from her loving, caring foster parents. Charlotte described being very close to her Nan, who passed away when she was nine. Unfortunately, Stacey and Patricia did not identify any source of support, suggesting they were either isolated in each domain of their social network, or, as highlighted previously, there was no one consistent enough to be identified as a source of support.

6.3 Difficulties as a parent with varied support and understanding
The second master theme captures the difficulties participants experienced as parents; feeling as though they wanted to escape sometimes and finding it hard to spend time with their children during periods of depression. Similarly to their early experiences, mothers felt isolated as they had a small social network for support. Mothers also felt misunderstood by others, including their children. They enjoyed accessing groups through mental health services as this normalised their experiences.
6.31 Theme four: I love my children but it is difficult to be a parent to them

Depression was the most common difficulty identified by participants as a barrier to being a parent; every participant identified experiencing depression at some point during motherhood, which made it difficult to want to be around their children or actively engage with them. What was most commonly identified amongst mothers was “post-natal depression”; following the birth of their children they felt a difficulty in bonding with the infant.

“I spent the first few months feeling quite detached. I knew I loved him... It was a case of if anything happened to him would I be that bothered and I know that sounds brutal” (Patricia)

Mothers were able to reflect on how their mental health difficulties had or will impact on their children, identifying that it usually impacted negatively on their children. Mothers who had younger children, they reflected on their concerns for the future, and how their mental health difficulties might impact on their children as they got older.

“Sometimes when he cries I get a bit angry and upset and I wanna run away, do stuff, and I – I get kind of snap- I get a bit snappy and angry and- but I don’t think it’s affected things so far but- but I think it could if I keep letting myself get really distressed when he’s around. I started having panic attacks again and he’s seen one or two of them and that- I don’t really want him to see them.” (Charlotte)

Patricia initially identified that she felt she was able to protect her son from her mental health difficulties at the moment, then went on to reflect that her depression and subsequent withdrawal was probably noticed by her son, despite his young age.
“Last year I was in a really, really bad place. [Son] would never know... Possibly I was more grouchy than normal and I probably pulled away from him, so he did know— that’s a lie! And I pulled away from him more and I didn’t care... someone outright asked me in group, if something happened to [son] would you be bothered? And I’m like no, I don’t wanna be a mum, I don’t want any of this” (Patricia)

In order to manage the anxiety and challenges of parenting, mothers often sought ways to escape from parenting. For some participants this meant getting back to work as an alternative to motherhood.

“I had like two weeks maternity leave and that was enough!... so my daughter went into full-time care when she was two weeks old” (Hayley)

For other participants they were able to draw in family members to provide respite from parenting. However, this sometimes meant that it was even more difficult when they had to get back into the parenting role.

“Sometimes I just wish that... he wasn’t around... Like when he goes to my parents’ house on the weekend I kind of don’t want him back... But I don’t know, just sometimes” (Charlotte)

Mothers also described how having a child made them feel trapped, if they did not have form of respite. Sienna described how it triggered feelings about her own childhood.

“If I wanted to run, I couldn’t run because I had her, but I didn’t want to leave her either... I felt very trapped... I don’t know if it’s the feeling of- that it brought up about being a child, I don’t know what it was... Sitting with my child brought up feelings about myself and my life and what I’d been through” (Sienna)
Although each of the mothers identified that they had struggled at some point with being a mother, they all expressed affection for their children, and that being a mother was rewarding in some ways.

"I don't want to over-parent [son] but I don't shuffle him round to after-school clubs, I want to spend time with my son because I want to protect him and he's actually quite entertaining to be with! (Patricia)

6.33 Theme five: Feeling uncertain about parenting skills leads me to seek support and feedback from others

Participants recognised that their children had been exposed to adverse events, but they were concerned that they had been perceived as a “bad mother” purely due to their mental health difficulties, rather than their abilities as a mother. There was a belief that social services were prejudiced against mothers with the BPD label. They felt social services’ lack of understanding of the diagnosis led them to make assumptions, resulting in a perception of BPD indicating poor parenting skills.

"Social services think you can't be a good mother with BPD, and they just-it's because they've got no understanding of it whatsoever... and I think that is the major issue. You get assigned with a particular label and all sorts of assumptions are made" (Patricia)

On the contrary, Leyla referred to the link between parenting and the BPD diagnosis, and felt that services did not appear to understand the support she needed in her role as a mother; with services minimising the significance of her difficulties in parenting.

"Even dealing with social services and with CAMHS [Child and adolescent mental health services], no one gets the whole- this child- this isn't a good
relationship because mum’s got BPD, no one kind of gets it, it’s almost like I’m having to wave the flag” (Leyla)

Although participants sometimes felt wary of social services, the participants recognised that they found parenting difficult and wanted help and feedback from others, as indicated by Leyla. This included accessing their family for support. Despite finding her mother emotionally abusive when she was younger, Katherine found visiting her mother helped when she found parenting difficult. While Jasmine could also access practical support from her family, she found it difficult to ask them for help in times of need as she felt that she was failing as a parent and had let her family down, linking back to how she felt in childhood (see second theme).

“When [daughter] was taken into care I did eventually have to tell my sister, but she got angry... ‘Why did you not tell us? This happened before and you never tell us’ but what they don’t get is it’s the sense of disappointment. I feel I’ve let them down AGAIN!... [When my daughter] was at home in [country] on holidays with me - that was just under the looking glass. I felt I was under the microscope, I felt that everything I was doing was wrong” (Jasmine)

Hayley and Charlotte spoke of accessing mental health services for support; because they did not have much support available outside of professional services. Other participants also spoke about groups for people diagnosed with BPD, including the SUN (Service User Network) project, Mentalisation-Based Treatment (MBT) and Dialectical Behavioural Therapy (DBT). Mothers spoke about a group being supportive as it normalised their experiences.

“Having other, like there’s two other girls in the group, having other people that think and feel exactly the same way gives you some kind of validation I suppose” (Katie)
Leyla found it helpful that the group put some pressure on her to overcome her self-harming, which she would not have done without that feedback.

"[Therapy group] almost stomped their foot and said enough, you've got to do the work, and you've got to stop the self-harming and the behaviours that take-those sort of mask all the emotions, because if you don't do it you're not getting the full benefit of the therapy and we won't work with you anymore" (Leyla)

One of the core functions of a therapy group is its ability to facilitate self-understanding through feedback from others (Montgomery, 2002); a much needed skill for those who have not developed reflective functioning skills.

One of the decision-making processes that mothers with BPD found particularly difficult was in disciplining their children. Hayley decided to correct her family script, as she recalled feeling hated by her mother when she was disciplined.

"Whenever my sister or I did anything wrong we were sent to the corner and it- and by the time we went to the corner we’re not crying because of what we did wrong we’re crying because mummy hates us and sent us to the corner!... I’ve decided if [daughter] needs to go to the naughty mat we’ll go together and just calm down together" (Hayley)

Leyla described giving disciplining responsibility to her husband. Although she did not like that he used the same disciplinary methods she grew up with, thus creating a replicative script of her own experiences, Leyla found this easier than disciplining herself.

"[With new husband] there was this sense of someone else has come in to help me parent? And so my first thing was ‘oh you do the discipline side of things’... [But] he’s come from [country] with all the traits of the [country] parenting that I
hated myself... he's quite into sort of punishment and beating and disciplining”

(Leyla)

6.34 Theme six: Children don't understand my mental health problems

Participants who had older or adult children felt sad that their children did not seem to sympathise with their mental health difficulties, and were often critical of them instead. There appeared to be more pressure on older children to be understanding and supportive. The difficulties in taking their children's perspective highlights the difficulties with reflective function this group might have, specifically in relation to parenting. Leyla highlights the “resentment” she experienced towards her adult children for not supporting her when she feels depressed.

“I think I'm annoyed with them to some point 'cause I think you got the best out of me, you got me when I was- and I probably wasn't at my best but I was functioning a lot better than I'm functioning now, and I feel like they're almost not being very kind err... supportive or... sympathetic to the situation?... [Eldest daughter's] kind of- sort of- she's like 'mental health, it's a very selfish disease mum, d'you know, having mental health'. So she's almost got no time for the whole- 'I don't wanna hear about it, pull yourself together’” (Leyla)

Katherine described how hurt she was when her son and daughter were “abusive” towards her, although this was in a context where she has also been verbally aggressive towards them. Stacey spoke of her daughter as volatile when she misunderstood Stacey's thoughts of “ending it”.

“[Daughter], she’s very volatile and like the other day I said 'I can’t cope’, I said 'I could end it, I could end it’, I was thinking if I could go upstairs I could take all my tablets... [Daughter] come over here and she grabbed hold of me and was screaming at me and she said 'I'm gonna have you sectioned' and I said 'why?’ 'Oh you're not
safe you know’ and I thought ‘oh, a couple of hours and I’ll come out of this dip’

(Stacey)

As Katie’s son was approaching adolescence, he had become more aware that
his mother’s mood could be inconsistent. Katie was able to utilise her treatment
service to provide information for her son on the BPD diagnosis and how and why it
made her act differently sometimes.

“It’s really important for me for him to know [about my diagnosis] because
sometimes he’s like ‘what’s wrong with you mum? Sometimes you’re okay and then
the next minute you’re like a different person’” (Katie)

6.4 Across the lifespan: patterns in childhood recur in motherhood

The third master theme focuses on themes related to how early experiences linked to
how participants managed the mother role. They found the emotion regulation
difficulties and coping strategies that developed in childhood/adolescence were
maladaptive in motherhood. Furthermore, while they attempted to protect their own
children from experiencing early adversity as they had, their children were often
exposed to adversity. This was usually linked to emotion regulation difficulties and
maladaptive coping strategies.

6.41 Theme seven: I find alternative ways of coping when support from
services isn’t available or helpful

Theme seven was conceptualised as an “across the lifespan” theme, as it
began in childhood and continued into motherhood. Participants spoke about ways of
managing their difficulties in ways that often led to damage of the self, usually self-
harming or suicide attempts, beginning around early adolescence. Triggers usually
related to interpersonal difficulties they were experiencing, such as abuse, bullying,
isolation, supporting van der Kolk’s idea (1989) of Developmental Trauma Disorder.
Stacey described her first overdose in response to the domestic abuse she was both witnessing and experiencing.

"I was cast as having bad nerves because erm I was- I was a mess, I was a fourteen year old mess, you know. The kids were out having fun and I'd be petrified about going back [home] wondering if my mum was there... Then they put me on antidepressants and then when I was about fifteen, I think, I tried taking quite a few because I didn't wanna be around anymore, I couldn't hack it, I couldn't hack what [step-father] was trying to do to me and I couldn't hack the hitting" (Stacey)

It seemed as though the women were unable to develop new coping strategies as they got older and entered motherhood, and the self-destructive methods of coping often exposed their children to scary situations, thus potentially traumatising their own children.

Sienna spoke about trying to push away the idea that the self-destructive behaviours she used to “cope with life” impacted negatively on her daughter, because that was easier than giving up the behaviours.

"The behaviours I use to cope with life is what [social services are] unhappy with... a part of me wants to try [therapy], but a part of me feels scared to try it... I self-harm, I over-medicate, and I drink alcohol... even though my home meets the standard... they're worried about the behaviours because they're life-threatening and what that means for daughter, and they've asked me if I believe that and I don't sometimes... But maybe that's because I find it hard to give up the behaviours” (Sienna)

Sienna's description highlights how it can be easier for mothers to deny the effects of their coping strategies, when the behaviours are the only effective way they have to cope with the overwhelming emotions they feel. Patricia, Hayley and
Charlotte, on the other hand, described how having their children motivated them to reduce or stop self-harming.

"I was a bit worried 'cause I had to stop doing all my self-harmy stuff... it was hard to adjust, it felt like I was losing some- a part of myself in a way. I had to change everything for [son]... I think having [son] helped more than the DBT, 'cause having him kind of meant I HAD to stop, whereas DBT didn't" (Charlotte)

6.42 Theme eight: I was taught to keep feelings inside but it leads to outbursts and violence

This theme also ran through childhood and adulthood reflecting a replicative family script for most participants who attempted to maintain the family script of not sharing emotions as adults. Participants referred to an unspoken message growing up that it was not safe to talk about emotions; therefore they learned to keep feelings, particularly negative feelings, to themselves. However, in trying to achieve this aim of keeping emotions inside, participants often had verbal or physical outbursts of emotion, which was sometimes aimed at their children.

Leyla spoke about trying to keep emotions inside while parenting, as she had learned to do so as a child. However, this then built up into a rage, which led her to have extreme mood swings when parenting her son.

Childhood:

"I remember being laughed at and told I thought I had more tears than everybody else and I was always crying. Things that would upset- I would- I'd get upset very quickly... I was always told don't show your tears, don't cry, you're annoying- it was almost an annoyance to everybody if I cried or anything, so there was never any comfort, it was just being told you were just stupid or silly" (Leyla)

Parenthood:
"I'd lose it, a month- three months would go by and [son would] knock over a glass of milk and the rage would come up for things he'd done all through that time, d'you know what I mean? And I'd just be like "argh!" this crazy person!... I'd swing from being this kind of monster in a rage, to being this mum who never, you know, everything was fine you know, and no problems" (Leyla)

Katherine also spoke about keeping emotions inside as she felt fearful of what reaction she might get from her mother, who she feared would abandon her. As she became a mother herself, her difficulties in regulating her emotions led to her eldest daughter moving out at sixteen.

Childhood:

"I never used to tell anyone [when I was upset], it's all kept inside. I never even used to tell my Nan... I was one of these weird kids; I never spoke very much... I suppose in fear that she'd- I'd be in trouble with my mum. I mean, I never even used to tell my dad that she was horrible to me while he was at work. It just never entered my head to tell- you just didn't tell" (Katherine)

Parenthood:

Katherine: "I didn't want [children] to leave home; I wanted them to keep them all (laughs)".

Interviewer: "Okay, how did you express that?"

Katherine: With anger really!... When [daughter] did come in [from seeing boyfriend] I was really cross and I hit her- I did hit her- I swung her round by her hair and hit her and that weekend she went up her mother-in-laws and she didn't come home no more"

Their difficulties with regulating and responding to negative emotions also made it difficult for participants in other relationships. Jasmine described breaking her
husband’s nose after he repeatedly made comments that her family didn’t love her and that they were ashamed of her, reinforcing her fears that she was a disappointment (see theme two).

Jasmine and Hayley spoke about their awareness of how their emotions can fluctuate and may lead them to snap at their children. They appeared to be trying to correct their family scripts, by being more mindful of when they were angry and whether they were unreasonably angry with their children due to their emotion regulation difficulties.

“I rarely did smack her because I thought if I’m not well and I’m feeling really down I could be smacking her for nothing and that’s not fair” (Jasmine)

Interestingly, while mothers tried to keep their own emotions inside, they attempted to correct their own early experiences by encouraging their own children to share their emotions. This is highlighted in theme nine.

6.43 Theme nine: Sometimes my children end up in similar situations to what I experienced but I try to do things differently to my parents

Conceptualising a recurrent theme throughout the participants’ narratives was the juxtaposition of good intention by the mothers to give their child a better experience of being parented, with the unfortunate and unintentional outcome that their children were also usually exposed to early adversity, usually related in some way to the mothers’ emotion regulation and interpersonal difficulties.

Jasmine spoke about wanting to do things differently to her parents as her parents disapproved of vanity and she wanted her daughter to know she was beautiful. However, in trying to praise her daughter’s attractiveness, which Jasmine wanted her mother to do for her, and reduce the likelihood her daughter would feel rejected, Jasmine had feedback from others that she was actually damaging her
daughter's confidence by commenting on her weight and appearance. This seemed linked to Jasmine trying to prevent her daughter from feeling the rejection she felt as a child.

"People are saying 'that's wrong of you, you're putting all these ideas in her head', but I don't want her to get fat, I don't want her to get obese, because that's more- that's more rejection" (Jasmine)

Hayley was hypervigilant to anything she might do that was similar to her mother, stating she would think "what would my mother do and then do the opposite". This suggested an element of reflectiveness to monitor whether she was parenting her daughter in a similar way to how she was parented.

"Sometimes when I find [daughter] crying and she's trying to, you know, trying compose herself or something, you know, I have to tell her, you know 'look [daughter] it's just you and me you can be sad. If you're in school maybe, but you're too little to understand the difference, it's tough right now- if you wanna be sad, you be sad!'... 'Cause I was never allowed- If I was upset about something I had to go to my room, we would never talk about it" (Hayley)

Similarly Charlotte was also adamant that she did not want to do anything similar to her parents, yet sometimes situations arose where she realised she had followed a similar pattern, for example, having a child-minder to look after her son following her experience of uncaring au pairs. However, she remained hopeful that as he got older that she would parent differently, by providing the support she felt she missed as a child.

"I can't think of anything I'd do that's similar to my parents... When he gets a bit older I'm gonna try and- try and listen to him, just be there for him, rather than just kind of dismiss anything he says." (Charlotte)
Despite their best intentions, there were often similarities between participants’ own early experiences and their children’s early experiences, for both positive and negative reasons.

A common story shared by participants was that their children had also experienced early adversity growing up, such as witnessing domestic violence and self-harm. Furthermore, a common experience for participants’ children was having an absent mother for periods of time, either physically or emotionally, due to periods of depression, a hospital admission, or a prison sentence.

“\textit{I saw [son] and [daughter] but the family decision was not to tell [youngest daughter] that I was in prison... she was told that I was in hospital but she couldn’t come and see me, so for four months I just kind of disappeared out her life, for four months. I spoke to her every- I did speak to her every night, I’d phone her up and talk to her, but I didn’t get to see her at all, and that was really hard for her}” (Leyla)

Katherine recognised that both she and her children had used self-damaging coping strategies to manage their emotions and interpersonal stressors, with one son committing suicide following a relationship break-up, and another son misusing substances.

“\textit{I found out since that he’s on the gear now, he’s lost his job a couple of times through drugs and I know he got in to drink big time}” (Katherine)

Going back another generation, participants also shared their views on their own mothers’ experiences of depression and the intergenerational patterns of mental health difficulties. Sienna recalled her mother taking overdoses and being very socially isolated. Patricia’s mother acknowledged that her own undiagnosed depression may have caused her to withdraw from her children.
“Mum did say to me a few years ago that although hers has been undiagnosed and she’s never been as low as I have, she’s pretty much suffered with depression all her life, which has meant that’s sort of- as we discussed it a little bit more that’s why she kind of withdrew” (Patricia)

6.5 Trustworthiness

6.51 Top-down analysis

To assess whether data saturation had occurred the themes generated from the analysis of the first six interview transcripts were applied to the final three interviews. The nine themes mapped onto the remaining three interviews, as exemplified throughout the results section with quotations from the final three interviews.

6.52 Staff focus group (SUN project)

A full account of the meeting is in appendix O. As found in the research, staff shared that common experiences for mothers diagnosed with BPD was a dialectic of lack of insight; when they perceive their parenting as adequate, versus self-blame and guilt for poor parenting practices. Participants were able to reflect on the impact of their diagnosis on how they parented. There were some signs of denial, rather than lack of insight, when mothers were considering the influence of their self-damaging behaviours. This appeared to be a self-protective coping mechanism, rather than lack of insight.

While participants identified group settings as supportive, staff members identified the risk of group settings for mothers diagnosed with BPD. In supporting one another they may position each other as “good” mothers, thus colluding with a mother’s denial of maltreatment. This could prevent insight into how their parenting practices may be adverse.
Staff highlighted that mothers diagnosed with BPD who have had children taken into care are commonly encountered in clinical practice; therefore, this group was under-represented in the research. While mothers who had looked after children were approached in the SUN project groups, they did not consent to taking part. Discussing their experiences of losing their child/ren may have been too painful. They may also have been wary of talking to a professional about their parenting practices, when it had historically resulted in losing their child/ren.

"Parentification" (Byng-Hall, 2002) was often noticed in clinical practice, when a mother diagnosed with BPD had adult children. While this was something the participants with adult children craved, their descriptions did not suggest signs of parentification. If the children had also been interviewed, this may have revealed a different narrative around parentification.

6.53 Reflections

My primary reflection on completing this research was on the overwhelming process of transcribing and analysing the interview data, not practically, but emotionally. I struggled to remain on task during this stage, finding myself making excuses to come away from the data. I wondered how this might be understood in terms of the recurring issue that participants had limited perceived social support, both personally and professionally, including from their adult children. Is it difficult for others to sit with the sadness their narratives instil?

Women diagnosed with BPD are often described as fixated on traumatic events when interviewed, making it difficult to remain coherent and on-topic in an interview (Agrawal, Gunderson, Holmes & Lyons-Ruth, 2004). I noticed that the participants often found it difficult to focus on the topic of being a parent. Was it difficult to focus on speaking about their relationships with their children when they
were preoccupied with more distressing thoughts/memories (Crittenden, 2006b)? Alternatively, was focusing on past difficulties or intimate relationships actually easier to attend to than their relationship with their children? This may have felt even more emotionally distressing, as it triggered feelings of guilt and self-blame, rather than blame attributed to others in early or intimate relationships.

Another reflection during this process was around mothers who had not accessed formal psychological therapy. They seemed to hold an idealised view of their upbringing and were reluctant to attribute any blame to their mothers for their current difficulties. However, from the narratives they shared there were signs that the environment they grew up in had, in fact, been challenging, which their mothers could not protect them from. They were often tangential, as though it was not safe to approach certain topics that not been processed in a safe environment. This really highlighted to me the importance of therapy for this client group, yet their experiences of relationships make this a long process, which is difficult in the current economic climate.
7. DISCUSSION

7.1 Overview

The themes outlined in the Results will be discussed in relation to the theories and research detailed in the initial review. New literature will also be introduced based on the results. The first master theme, “Early adversity with limited support”, relates to the early experiences of the participants; growing up in environments where they did not feel loved and/or safe, with no one to turn to for support. The second master theme, Difficulties as a “parent with varied support and understanding” focuses on the challenges participants faced in motherhood. They identified wanting to escape from their children and finding parenting a challenge when they felt depressed. They found it particularly difficult to manage motherhood with limited support, although some gained support through groups for individuals with the BPD diagnosis. They felt they were misunderstood by others, including professionals and their own children. The final master theme, “Across the lifespan: patterns in childhood recur in motherhood”, highlights how emotion regulation difficulties and coping strategies that emerged in response to early experiences were unhelpful in participants’ roles as mothers. Finally it highlights how mothers attempted to parent differently to their own parents, but sometimes their children were also exposed to early adversity.

7.2 Early adversity with limited support

7.2.1 Theme one: Signs of anxiety in childhood due to early adverse experiences

As the women described their childhood experiences, their narratives supported the idea that they had insecure attachments to their caregivers, with high levels of anxiety in childhood and/or adolescence and a sense that there was nowhere safe to go to when they felt sad or scared (Bowlby, 1969). The types of adversity in
childhood varied between participants, but they held in common an interpersonal element, lending support to the developmental trauma literature proposed by van der Kolk (1989). As children, they had little access to caring and consistent adults, leading to an overwhelming sense of anxiety in childhood.

Some women spoke about growing up in invalidating environments similar to those described by Linehan (1993) as "chaotic families", where the needs of the children are disregarded in favour of the parents' own needs. Growing up in a fearful environment where the parent focuses on self-protective behaviour at the expense of the child's protection, gives participants the message that other cannot be relied on or trusted (Crittenden, 2006a; Crittenden, 2006b), leaving the participants feeling helpless and isolated. However, in learning that others cannot be trusted, participants began to further isolate themselves as they grew older from individuals outside the family home. This limited their opportunity for external support and experiences of a different type of attachment.

Jasmine, Hayley and Patricia appeared to grow up in a system in which the parents cannot tolerate displays of negative emotion from their children, and achievement and mastery are markers of success. In these instances, the women also appeared as though, or reported that, they felt they were held to high expectations by their parents, in a different way to their siblings. Linehan identified (1993) the "perfect family" as an invalidating environment. While these participants did not necessarily experience chaotic early adversity, they grew up in an environment which hindered their ability to regulate their emotions and where love was conditional. Their emotions were not validated as understandable by caregivers, but rather they were dismissed as too sensitive.
The mothers each shared experiences of parenting consistent with emotional abuse or neglect. Historically, abuse literature has focused largely on sexual or physical abuse, yet recent studies consistently find that emotional abuse and neglect are associated with the symptoms of BPD (Bierer, Yehuda, Schmeidler, Mitropoulou, New, Silverman & Siever, 2003; Johnson, Cohen, Chen, Kasen & Brook, 2006; Lobbestael, Arntz & Bernstein, 2010). This suggests greater emphasis needs to be placed on emotional abuse/neglect when considering the early experiences of those diagnosed with BPD, and when working with children/adolescents showing signs of low mood or anxiety.

The signs of distress from an early age, usually pre-adolescence, lend much support to the importance of early intervention with individuals who have grown up without the experience of having their emotions regulated by others and who have not been able to develop trusting relationships (Bowlby, 1969). The concept of emerging Personality Disorder (ePD) in adolescence (Miller, Muehlenkamp & Jacobson, 2008) has strong evidence for responding to early intervention (Chanen, Jovev, McCutcheon, Jackson & McGorry, 2008). Individuals with the aforementioned difficulties could be provided with an evidence-based intervention earlier, with the additional opportunity to have an experience of a supportive and validating relationship with their therapist. This could reduce the likelihood of emotion regulation and interpersonal difficulties extending into adulthood.

7.22 Theme two: “I’m like a square with circles”: Feeling different and a disappointment to others

Participants described feeling different from, and subsequently isolated from, others. While this was related to the relationship described with their parents, they lacked a sense of belongingness both at home and at school, suggesting a global
experience of loneliness and isolation. Participants showed low levels of trust due to their caregiver attachment. Understandably, they subsequently found it difficult to build trusting relationships with others in childhood/adolescence, thus becoming lonelier (Rotenberg, 2010). Furthermore, the working model that others cannot be trusted was reinforced by their interactions with peers.

For some women in the current study, they actively isolated themselves from peers; for others they were rejected or ignored by peers. This illustrates the mothers’ home experiences reflected in the school environment, whereby they maintained the “rejected” role at school or moved into a “rejecter role”, thus gaining control by rejecting peers first (Ryle, 1992). In either scenario, the participants did not have an opportunity to develop trusting relationships with their peers, and have a different experience of an attachment relationship. Linking to Crittenden’s (2006a) model describing self-protective strategies in adverse environments, individuals may oscillate between social withdrawal, to avoid the stress and confusion of relationships, and aggression towards peers, as this enables a sense of control that the individual craves (Howe, Brandon, Hinings & Schofield, 1999).

Another way in which the mothers interviewed were made to feel different was in the way they were treated in comparison to their siblings. Participants reported that a sibling was often given preferential treatment to them in some way or that siblings were treated similarly by parents but it did not affect them in the same way. Laporte, Paris, Guttmann, Russell & Correa (2012) found that women diagnosed with BPD and “healthy” sisters reported similar levels of intra-familial abuse, but individuals diagnosed with BPD reported the abuse as more severe. While participants most likely were treated more negatively by their family, it also suggests the possibility that women who go on to receive a diagnosis of BPD experience
abuse as more severe than their siblings, due to the more global sense of difference and isolation. Their temperamental vulnerability (Linehan, 1993) may also heighten the feeling of loneliness (Qualter, Brown, Rotenberg, Vanhalst, Harris, Goossens, Bangee & Munn, 2013). Additionally, “healthy” siblings may have got their needs met elsewhere through other relationships.

7.23 Theme three: Mum didn’t support me growing up so I sought alternative support

Following on from the previous theme, mothers in the study sometimes accessed alternative support outside of peer groups. Drawing on the literature of resilience, while mothers who took part in the research mostly found their mothers rejecting and/or neglectful, they often sought support and guidance from other individuals in their network, including teachers, siblings, or grandparents. Research on resilience has continued to highlight that quality relationships across the lifespan are of the essence in promoting psychological well-being in adulthood, particularly when childhood abuse has occurred (Collishaw, Pickles, Messer, Rutter, Shearer & Maughan, 2007). Each participant was able to identify a person who was emotionally available to them growing up; however, a crucial issue appeared to be that this person who was available for support had not been able to protect them from the impact of the adverse life events they had experienced. Linking back to the first theme, participants wondered why people outside the family home were not more concerned for them considering how anxious or low they had been as children. Why did Katherine’s family not persist in reprimanding her mother for the way she treated Katherine? Why did Leyla’s teachers not raise their concerns when Leyla repeatedly requested to stay at school at the end of the school day?
Linking resilience\(^9\) with attachment theory, it seems that while participants had a supportive individual in their network, their inability to protect the participant prevented them from developing a secure base whereby the participant felt safe and able to withstand the adverse experiences (Walsh, 2003). Furthermore, resilience develops in parallel to competencies in forming, maintaining and benefiting from supportive interpersonal relationships (Collishaw, Pickles, Messer, Rutter, Shearer & Maughan, 2007). As highlighted in theme two, participants' narratives suggested global loneliness. There did not appear to be a consistent supportive figure throughout childhood and adolescence, suggesting there was not enough stability in their alternative support for participants to develop resilience. This may provide some explanation as to why participants developed the self-damaging strategies to manage their affect; with little opportunity for social learning of more adaptive coping strategies (Zimmer-Gembeck & Skinner, 2011). This highlights a risk period for individuals exposed to early adversity; adolescence may be a crucial time to provide an intervention.

7.3 Difficulties as a parent with varied support and understanding

7.3.1 Theme four: I love my children but it is difficult to be a parent to them

Co-morbid post-natal depression (PND) and a diagnosis of a personality disorder is a relatively new, but interesting, area. Research has found that PND only influences infant care practice and maternal involvement when the parent had a co-morbid personality disorder. Furthermore, personality disorder independently influences infant care practice and maternal involvement, without co-morbid PND (Conroy, Marks, Schacht, Davies & Moran, 2009). Disappointingly, only one mother

\(^9\) An ability to "bounce back" from adversity (Walsh, 2003).
had received her diagnosis of BPD prior to having a child, signifying the importance of early intervention with this group. In doing so mothers may learn skills in managing the challenges of parenting, leading to increased resilience (Hill, 2007). Conroy et al.’s (2009) findings contrast with the current study, whereby mothers reported that parenting was most difficult when they experienced periods of depression. It became very difficult to focus on the needs of the child, rather than their own difficulties during these times (Crittenden, 2006b).

Mothers also spoke about wanting to “get away” from their children, and often sought respite in going to work or having their children looked after by others. However, due to participants’ difficulties in developing trusting relationships, they are likely to have fewer social contacts in their network (Stepp, Pilkonis, Yaggi, Morse & Feske, 2009) and are less likely to have a support network consisting of positive relationships (Clifton, Pilkonis & McCarty, 2007). This is more likely to leave the mother with a sense of feeling isolated, overwhelmed and vulnerable as a parent, thus seeing the child as a threat (Crittenden, 2006). The idea of wanting to “get away” from their children seemed closely linked to feeling overwhelmed in the presence of the child. It appeared that mothers felt they had to give themselves completely when they were with their child, possibly in an attempt to correct their own family script where the mother is emotionally and/or physically distant (Byng-Hall, 1996). In their clinical observations of working with mothers diagnosed with BPD, Newman & Stevenson (2008) noticed that mothers were uncertain of what they were supposed to do with the infant, and may resent giving the child attention when they were not given attention as a child themselves. Participants seemed unsure what to do when faced with the desire to run away, and had a lack of social support to seek support in and/or feedback from parenting.
Alternatively, Leyla described planning to commit a homicide/suicide prior to a prison sentence; wanting to end her life, but not wanting to leave the children alone. This highlights the most extreme form of parenting distortion described by Crittenden (2006a), whereby a parent perceives themselves and the child as in danger and attempts to relieve the overwhelming feeling of desperation and loneliness (Crittenden, 2008).

7.33 Theme five: Feeling uncertain about parenting skills leads me to seek support and feedback from others

Santayana’s quote (1905, p. 284); “those who cannot remember the past are condemned to repeat it”, highlights the importance of reflective function in being able to alter intergenerational patterns of parenting. A mother first needs to be aware that the way she was raised was not “good enough” care, in order to be able to parent differently. One aspect in which mothers interviewed experienced great uncertainty was the use of discipline in the home; they were particularly concerned about how their mental health difficulties, particularly emotion regulation difficulties, would impact on how they disciplined their child. Were they being too harsh because they were depressed or anxious? Parents who are both anxious and use harsh discipline methods are more likely to have a child with signs of low mood and/or anxiety (an “internalising disorder”) (Laskey & Cartwright-Hatton, 2009). In order to manage this dilemma, mothers often drew on their social network for knowledge on discipline. Some resorted to replicative scripts; using the same methods of discipline as their parents; a common approach to discipline in the general population (Chung, Mathew, Rothkopf, Elo, Coyne & Culhane, 2009).

Interestingly, mothers did not mention seeking advice from professionals regarding discipline, which was possibly linked to their fear of being perceived as a
“bad mother” due to their mental health difficulties. Individuals diagnosed with BPD typically have longer-term interpersonal and emotion regulation difficulties (rather than a discrete period of poor mental health), and a reputation of poor engagement with professionals. As a result, they are perceived to present a greater risk to their infants (Westman, 2000) by health and social services. While mothers with other mental health difficulties have concerns regarding how they are perceived by services (e.g. Davies & Allen, 2007), research shows that when mothers’ symptoms decline their levels of parenting stress reduce, and their nurturance increases (Kahng, Oyserman, Bybee, & Mowbray, 2008). As participants became aware of the stigma associated with their diagnosis, it is not surprising that they perceived health and social services as persecutory rather than supportive. This raises important issues for mental health and social services when considering how best they can support mothers diagnosed with BPD to feel comfortable to access services without the fear that their children will be taken into care.

Only two mothers reported input from mental health professionals in relation to their role as a parent, despite one mother recently having her child taken into care. Instead of intervening to prevent future difficulties in a parenting role, professionals may react after a concerning event has taken place, thus reinforcing the mothers’ perception of the self as “bad”. While mothers accessed evidence-based treatments, such as DBT (Linehan, 1993) and MBT (Bateman & Fonagy, 2004), these were not targeting skills in parenting per se. In their chapter on MBT for parents with a diagnosis of BPD, Nijssens, Luyten & Bales (2012) state that standard MBT does not foster capacity for parental reflective function, i.e. an ability to visualise the infant in terms of internal mental states. Thus, in order to disrupt the intergenerational transmission of emotion regulation difficulties, programmes for mothers with BPD...
should specifically target their role as a parent (Nijssens, Luyten & Bales, 2012), as well as skills related to the difficulties associated with BPD. As highlighted by Sienna, participants may not have had opportunities to learn skills necessary to parenting, such as diet. Clinicians have also suggested psychoeducation interventions for mothers diagnosed with BPD (Stepp, Whalen, Pilkonis, Hipwell & Levine, 2012). This additional practical intervention could allow mothers to seek advice on practical issues, including diet and discipline, in a safe, non-judgemental environment.

7.34 Theme six: Children don’t understand my mental health problems

Mothers who had older children reflected on their children’s perception of mental health. Parentification is a type of role reversal whereby the mother adopts the vulnerable child role and the child adopts the parent role (Byng-Hall, 2002; Crittenden, 2006a). Interestingly, there was little description of the parentification often described when a parent has mental health difficulties (Reder & Lucey, 2000).

Mothers of adult children in the current study shared narratives of their disappointment in how their children viewed their mental health difficulties, whereby it appeared as though they desired their child to adopt a parental role. Katherine described her children as abusive towards her on several occasions, without fully recognising the dual process in that she was also verbally abusive towards them. Stacey also spoke of her disappointment that her children perceived her as egocentric.

Using the concept of parental reflective function, the participants perceived these interactions as a sign that their children did not care about them, suggesting they had difficulty considering the child’s internal mental experience that lies behind their behaviours (Nijssens, Luyten & Bales, 2012). The mothers seemed to find it
difficult to consider the underlying hurt and pain their children might be expressing through their frustrated words. Furthermore, it may have been easier and more self-protective for children to get angry at their mothers for their mental health difficulties, as the alternative may have been parentification, which can be detrimental to a child's psychological well-being (Abraham & Stein, 2013), self-blame (Trout, 1991), or depressed helplessness (Crittenden, 2006a).

7.4 Across the lifespan: patterns in childhood recur in motherhood

7.41 Theme seven: I find alternative ways of coping if support from others is not available or helpful

Mothers who took part in the study spoke of various methods to cope when they experienced traumatic or difficult life events and interpersonal disputes, for example, suicidal ideation following the break-down of a relationship, rape, or a prison sentence. Maladaptive ways of coping are often what initially brings individuals diagnosed with BPD to the attention of mental health services (NICE, 2009). It was clear from the mothers' narratives that self-damaging ways of coping with difficult or traumatic events began in early adolescence and continued into adulthood, suggesting mothers had not learned new methods of coping as they developed.

In keeping with the literature, participants described "impulsive" responses towards solving social problems and appeared to have fewer solutions (Bray, Barrowclough & Lobban, 2007), particularly when mothers were faced with interpersonal situations that triggered negative affect (Dixon-Gordon, Chapman, Lovasz & Walters, 2011). For example, Jasmine's description of taking an overdose following a relationship break-up. Unfortunately, resorting to self-damaging behaviours as coping strategies increased the likelihood of involvement from social
services (a fear described by mothers in theme five). This leads to greater negative affect, whereby self-destructive behaviours are likely to be used again to cope. It is easy to see how mothers can become stuck in a vicious cycle in this scenario, feeling helpless and out of control.

These strategies were often used following an interpersonal event that triggered overwhelming pain for the mothers, such as an argument with parents that led Charlotte to believe they hated her. The central theme of aloneness in these examples, either real or perceived, becomes the central focus for the mothers. As described by Crittenden (2006b), in these scenarios mothers are likely to overestimate the threat to the self, making it difficult to focus on their child's needs. While mothers did not report self-harming due to difficulties with parenting, children of mothers diagnosed with BPD have reported they believed they were responsible for their mothers suicide attempts (Trout, 1991).

As discussed earlier, individuals with a diagnosis of BPD are less likely to receive support in their social network; therefore the professional network seems even more important for this group. However, due to their early experiences and experiences of stigma, they will often have difficulties in developing trusting relationships with professionals (Fallon, 2003). In line with NICE guidance (NICE, 2009) most mothers spoke of attending various types of groups as part of their treatment/support programme. Overall, mothers were generally positive about their experiences of being in groups, as a space to develop the skills they had not had the opportunity to learn in childhood. In developing the skills associated with MBT or DBT, mothers are less likely to rely on their previous coping strategies, such as self-harm or alcohol use.
Theme eight: I was taught to keep feelings inside... but it leads to outbursts and violence

Part of the diagnostic criteria for BPD relates to emotion regulation and expression, specifically a "marked reactivity of mood" and "inappropriate or intense anger" (DSM-V, 2013). Theme eight represented another dilemma participants faced in their role as parents; trying to keep emotions inside, but they were eventually expressed in extreme forms through verbal or physical aggression.

Linked to the invalidation of emotions (Linehan, 1993), participants also focused on the imposed restriction on emotions growing up. Mothers described a persistent message from family members that emotional expression was not acceptable, thereby participants grew up in environments with caregivers whose coping strategies focused on cognition over affect, avoiding contact with others (including their children), and dismissing the importance of intimacy and trust. When considering resilience develops in an environment with open communication and collaborative problem-solving (Walsh, 2003), it is not surprising the participants had difficulties coping with stressors, including in their role as a parent.

Although mothers tried to keep their emotions to themselves as they grew older, attempting to adopt a coping style whereby they avoided expressed emotion and reliance on others, they often felt their emotions spilled out in a more extreme fashion. This had a detrimental effect on their relationships, including the relationships with their children. Mothers spoke of out-of-proportion shouting at, or even striking their children, when they were more emotionally aroused (particularly when depressed or anxious). This suggests a possible intergenerational pattern of alternating between low expressed emotion (EE) (avoidant coping styles) and high EE (anxious-ambivalent coping styles). This pattern has been found in the literature.
as an infant’s adaptation to their caregiver in order to elicit caregiving behaviour (Shah, Fonagy & Strathearn, 2010). If the participants’ mothers showed low EE, they would adopt a high EE strategy to elicit attention from their mothers. Whereas, if a mother showed high EE, a child is more effective if they show less EE, thus focusing on the mothers’ needs.

Linking back to theme seven, on coping through self-damaging behaviours, theme eight reflects another example of the participants’ difficulties in knowing how to respond to overwhelming negative emotions in interpersonal situations. When considering these two themes together, it highlighted a “no-win” situation for participants. BPD is associated with C5-6 strategies (see Appendix C) (Crittenden, 2006a); oscillating between mistrust and blaming of others, to desperately seeking care-giving from others that was missed in childhood. When others are blamed there are aggressive outbursts, however, when caregiving is sought, the self is blamed, thus leading to self-damaging behaviours. It would be difficult to have an infant if one adopts such strategies; potentially blaming the child for their difficulties, or seeking care-giving behaviour from their child. Unsurprisingly, C5-6 strategies emerge in adolescence, when early signs of emotion regulation and interpersonal difficulties become more pronounced. These are potentially identified as signs of “emerging personality disorder”.

7.43 Theme nine: Sometimes my children end up in similar situations to what I experienced but I try to do things differently to my parents

The well-known quote “the mother of every borderline is herself a borderline” (Masterson, 1972, p. 22) suggests the inter-generational transmission of BPD. Did mothers describe repeating the same parenting style they experienced as a child?
Mothers’ descriptions of attempting to correct the family scripts they grew up with emphasised that participants had reflected on their early experiences, and were actively attempting to give their children a different experience of being parented. However, the dilemma in this theme was that sometimes their children were still exposed to adversity.

As detailed in themes seven and eight, mothers often had difficulties in regulating their emotions in interpersonal situations which led to self-damaging behaviours or verbal/physical aggression, similar to what the participants had experienced growing up, for example, domestic violence or maternal depression. While participants were doing their best to change their children’s experiences, there were continuities between the generations. When considering the role of family scripts, it appeared mothers tended to repeat their own early experiences of exposing both themselves and their children to potentially adverse situations, particularly in the context of domestic violence or emotional distance amongst family members, usually due to periods of depression or other life stressors that impacted on parenting.

Mothers who were interviewed were sometimes re-exposed to trauma as adults in relationships that involved domestic violence. Mothers who experience domestic violence or other relationship difficulties, as described by Crittenden (2006b), focus on protecting themselves, thus leaving them emotionally distanced, unavailable, or sometimes abusive towards the child (Hester, Pearson & Harwin, 2006), creating a replicative family script. The mothers’ difficulties in their own intimate relationships highlight the wider context of being a mother diagnosed with BPD. Their child is further at risk of growing up in an environment with hostility or violence in intimate relationships (Fruzzetti, 2012). While interventions that target
this client group need to focus on both the parent-infant relationship, they should also focus on the mother’s intimate relationships.

With the exception of Charlotte and Patricia, both of whom had younger children, the mothers interviewed described being estranged from their children’s father, with some detailing that the relationships had been abusive or hostile. Charlotte and Patricia both emphasised the important role their partners played in parenting, particularly when they were feeling exhausted or depressed. Unsurprisingly, literature confirms that involvement in a positive intimate relationship as an adult, and support in the parenting role, can help to change negative intergenerational patterns, as the family scripts of the parents are adapted to accommodate the partner’s family script (Cowan & Cowan, 2005). However, this change inevitably depends on the father’s family scripts. In mothers’ descriptions of their partners, there were themes of domestic violence and paternal mental health problems. It appeared as though the participants were almost replicating their parents’ marital relationships, highlighting another intergenerational pattern.

Mothers in the research study described attachment styles consistent with an insecure attachment to their parents, as predicted by research with women diagnosed with BPD (Agrawal, Gunderson, Holmes, & Lyons-Ruth, 2004). The early adversity their children were exposed to, and limited alternative caregivers, suggests most participants’ children were also likely to develop an insecure attachment style. One protective factor in this instance might be the relationship developed with the father or other alternative caregivers. If alternative caregivers were able to foster a secure attachment with the child, the child has a better chance of developing skills in emotional regulation and reflective function, thus developing earned security. However, considering the narratives shared by some participants, it seems that most
of their children would have developed insecure attachments to both parents, due to the unpredictability of the environment.

Research suggests that infant attachment style is heavily influenced by maternal reflective functioning over the parent’s attachment style (Slade, Grienengerber, Bernbach, Levy & Locker, 2005). Therefore, while the participants’ children may have been exposed to early adversity, the important factor in changing the intergenerational pattern was the opportunity for the child to have the experience of another person to understand their internal world and help them to process it. Participants who remained in a relationship with the father of their child described the support derived from this relationship; thus highlighting this as a protective factor for both the participant and the child. Alternatively, Leyla, Sienna, and Katie all described utilising mental health services to offer their children a space to process their experiences, suggesting they may have been aware that they would have difficulty in facilitating this.

7.5 Implications

7.51 Implications for clinical practice and service development

7.511 Formulation approach

In identifying commonalities across the different interviews, it was noted that there was a uniqueness to each individual narrative and experience, despite all the mothers interviewed having the “BPD” label. In understanding how to work with mothers diagnosed with BPD, what seems most important is the use of an individualised/formulation approach (DCP, 2011). In order to understand the mother’s own early experiences and consider what difficulties she might face in parenting, it makes more sense to formulate “the experiences that may have led to a psychiatric diagnosis” (pg. 12, DCP, 2011), rather than the behaviours a person
presents with. In introducing categories such as complex PTSD or developmental trauma, this is a step towards a formulation-based understanding of mental health difficulties, and away from the medical model, whereby the person is positioned as the “problem”. Adopting a formulation approach to working with this client group can reduce the negative staff attitudes that have emerged in relation to the diagnosis (see Rogers, 2013, this portfolio, for a review of these issues), and promote an understanding of why mothers respond to people (including their children) in the way they do. When considering the early experiences and “across the lifespan” experiences found in the analysis, it is easy to identify why mothers respond in the way that they do. While this does not excuse their actions, enhancing clinicians’ empathy towards this client group is likely to enhance treatment optimism and promote therapeutic engagement.

7.5.12 Interventions for the mother-infant relationship

There is emerging research on the use of feedback following mother-infant observations to develop the mother-infant relationship (Newman & Stevenson, 2005; Jones, 2006). While some mothers might require more therapeutic work around developing a relationship with their infant (Jones, 2006), some mothers will also require practical advice on discipline and meeting the child’s basic needs (Stepp et al., 2012).

7.5.13 Early intervention for those with features of BPD

Earlier identification and intervention for adolescents with emotional regulation/interpersonal difficulties should be offered, to reduce the likelihood of growing symptom severity in adulthood. Mothers who have developed earned security are more likely to form a secure attachment with infants compared with “insecure” mothers (Saunders, Jacobvitz, Zaccagnino, Beverung & Hazen, 2011),
thus early intervention for this group is crucial. However, a recent survey amongst psychologists found that only 6.5% of surveyed psychologists provided ePD-specific interventions (e.g. emotional regulation skills or mentalisation skills) (Laurenssen, Hutsebaut, Feenstra, van Busschbach & Luyten, 2013). This group are potentially neglected or treated incorrectly by child and adolescent mental health services at present.

Similarly, early intervention for mothers diagnosed with BPD also needs to be considered by perinatal teams. Participants frequently identified that there was little input offered to support them during this period.

7.514 Systemic interventions

Mothers' early difficulties were largely exacerbated by an unsafe and/or unsupportive environment, with later difficulties as a mother following the same pattern. For mothers with a diagnosis of BPD, they are unfortunate in that they have a limited social network to turn to for support, but they are also fearful of the professional network, as they risk being identified as a “bad mother”. Working with this group inevitably requires a focus on systemic support for the individual, both in their personal and professional network. Research into parenting following a trauma emphasises the important of a systemic, multi-disciplinary approach (Appleyard & Osofsky, 2003). Promising research in Italy has found that a group intervention for individuals diagnosed with BPD and their family members showed favourable initial results (Ridolfi, 2013).

7.52 Implications for policy and training

7.521 NICE guidelines

NICE guidelines on post-natal/maternal care (NICE, 2013) make reference to the diagnostic categories to be considered when working with new mothers.
Interestingly, parents who have a diagnosis of BPD are not mentioned in the guidelines, despite their vulnerabilities in this role. They are likely to be isolated and the parent role may trigger painful feelings about their own early experiences, as highlighted by Sienna. Furthermore, NICE guidelines on the treatment and management of individuals diagnosed with BPD do not refer to motherhood in this group. Future guidance on working with new mothers should emphasise the need for support for mothers with a diagnosis or features of BPD, in helping them to manage in their new role.

7.522 Staff attitudes

Training has been identified as effective in changing staff attitudes towards the diagnosis of BPD, at least in the short-term (Commons Treloar, 2009). In understanding the mothers’ behaviour, clinicians are better placed to facilitate change. An excellent example of this is the formulation approach described by Lake (2008) when working with staff teams. Staff have described team formulations as a helpful “time out” to think about clients (Summers, 2006).

There is a clear association between maternal BPD features and involvement with child social services (Perepletchikova, Ansell & Axelrod, 2012). Unsurprisingly, participants, who have historically learned not to trust others, were wary of social workers. Training programmes could focus on workers in social services, specifically how they build a trusting relationship with mothers diagnosed with BPD, enabling mothers to access support when needed.

7.53 Future research

7.531 Social services

Future research may benefit from looking into the influence of social support for mothers with BPD and how this influences the involvement of social care.
services. This could have important implications for managing service demands and assessing need.

7.532 Early intervention

"Emerging personality disorder" and "developmental trauma disorder" both conceptualise young people who present to services with emotion regulation and interpersonal difficulties in the context of early adversity (Miller, Muehlenkamp & Jacobson, 2008). Research focusing on treating this group could reduce the likelihood that emotion regulation difficulties will be as prominent in adulthood; a difficulty that mothers felt impacted on their parenting ability.

7.533 Improved access to support

Improving access to services for mothers with a diagnosis of BPD who have a small support network is central. Mothers spoke about the importance of having time away from their children; however, this was heavily dependent on having a support system in place to provide respite. Research assessing the influence of personal and professional support on maternal and child mental health could provide vital information for service development in mental health and perinatal health.

7.6 Limitations

While care was taken to ensure the study was well-conducted, there are several identified limitations that need to be considered.

A major issue was the challenge of recruitment to the project. There were several possible reasons for this, which can be considered when researching into this group in the future. Firstly, mothers diagnosed with BPD are often fearful of the social care system and the risk of saying something that may mean their children are taken into care may have made them reluctant to take part. Furthermore, a number of interested participants arranged a meeting to complete the interview, but never
attended the appointment or cancelled on the day of the appointment. Approximately
two thirds of all the interviews arranged did not go ahead due to participants not
arriving or last-minute cancellations (approximately eighteen potential participants).
This highlights a significant difficulty in recruiting this group that needs to be taken
into account in future research, with sufficient time allowed and wider recruitment
options. This also suggests a limitation in the sample recruited; participants who
attended the interview were possibly more likely to be functioning better.

Originally it was decided that mothers of school-age children would be
recruited into the study, however, due to the aforementioned difficulties in
recruitment this inclusion criteria was expanded to include mothers diagnosed with
BPD with children of any age. The findings may have been more helpful and focused
if they were restricted to a specific age range of children.

One of the widely identified limitations of qualitative research is the
perceived subjectivity of the analysis; a process inevitably influenced by prior
knowledge and experience, as well as personal beliefs and values. It was important to
keep a reflective diary during the interviews and analysis, to remain aware of how
any of the aforementioned points may have biased the analysis (see Appendix P).
Supervision sessions were also held during the analysis to reflect on the themes
generated and assess how representative they were of the data. Furthermore, a focus
group with the SUN project team enabled an understanding of how well the themes
represented their experiences of working with mothers diagnosed with BPD.
8. CONCLUSION

To date, there has been no identified qualitative research published on mothers diagnosed with BPD, despite their difficulties in emotion regulation, relationships and mentalisation; crucial skills in motherhood. Early adverse experiences of attachment relationships left mothers with maladaptive skills in emotional regulation and building trusting relationships. The current study confirmed that mothers find their parenting role difficult and wanted to escape, particularly when depressed or when there is little opportunity for respite. However, mothers also spoke of a desire for support and advice, but they were fearful of being perceived as “bad mothers” leading them to avoid contact with a professional network. Mothers aimed to parent differently to their own mothers, but their children often experienced adversity during their own upbringings. Early intervention is crucial in terms of identifying and treating emotion regulation difficulties early on in adolescence and motherhood. The development of a personal and professional network should also be a core focus of intervention to enable mothers to develop trusting, supportive relationships. As highlighted by Patricia in the opening quote, in doing so it can reduce the likelihood of transgenerational exposure to early adversity.
9. REFERENCES


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10. APPENDICES

APPENDIX A. Diagnostic criteria for Borderline Personality Disorder.

APPENDIX B. Strange Situation Procedure.

APPENDIX C. Dynamic Maturational Model (Crittenden, 2006a).

APPENDIX D. Proposed diagnostic criteria for Complex PTSD and Developmental Trauma Disorder.

APPENDIX E. Crittenden's theory of parenting.

APPENDIX F. Tabular summary of quantitative research with mothers diagnosed with BPD.

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APPENDIX H. Participant information sheet.

APPENDIX I. Charity internet advert.

APPENDIX J. Interview schedule.

APPENDIX K. Table detailing participant information.

APPENDIX L. Participant consent form.

APPENDIX M. Transcript annotations.

APPENDIX N. Table of themes

APPENDIX O. Findings from the staff focus group.

APPENDIX P. Reflective diary excerpts.
APPENDIX A.

Diagnostic criteria for Borderline Personality Disorder.
DSM-5 (American Psychiatric Association, 2013)

(1) Frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.

(2) A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation

(3) Identity disturbance: markedly and persistently unstable self-image or sense of self

(4) Impulsivity in at least two areas that are potentially self-damaging (e. g., spending, sex, substance abuse, reckless driving, binge eating). Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.

(5) Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour

(6) Affective instability due to a marked reactivity of mood (e. g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)

(7) Chronic feelings of emptiness

(8) Inappropriate, intense anger or difficulty controlling anger (e. g., frequent displays of temper, constant anger, recurrent physical fights)

(9) Transient, stress-related paranoid ideation or severe dissociative symptoms
APPENDIX B.

Strange Situation Procedure.
The strange situation procedure (Ainsworth and colleagues, 1978)

The strange situation procedure (SSP) is a tool used to identify an infant’s attachment style. There are seven steps to the SSP, which results in an attachment style category.

**Step 1. Preparation**

The toddler is free to explore a room with toys while the parent sits quietly.

**Step 2. First appearance of the stranger**

A stranger comes into the room and speaks with the parent. The stranger then approaches the toddler with a toy.

**Step 3. First separation**

The parent leaves the room and the stranger leaves the child to play with the toys.

**Step 4. First reunion**

The parent returns awaiting a response from the toddler. The stranger leaves.

**Step 5. Second separation**

The parent leaves the room again once the toddler has settled. The toddler is alone.

**Step 6. Second appearance of the stranger**

The stranger re-enters and tries to interest the child with a toy.

**Step 7. Second reunion**

The parent re-enters and waits for the toddler to respond. The stranger leaves.

While the Strange Situation procedure is widely recognised as an attachment classification tool it is not without its criticisms. Namely the rigidity of the categories does not necessarily encompass the varied behaviours an infant can present with. Furthermore, the attachment style shown in the procedure may depend on the caregiver present. Additionally, the categorical nature does not account for the varying degrees of behaviour shown during the procedure, and could possibly be better represented on a continuum.
APPENDIX C.

Dynamic Maturational Model (Crittenden, 2006a).
**B3:** This is a balance of using both cognition and affect to identify behavioural strategies. They are able to adapt to most situations in order to protect themselves and others. There is little sign of either cognitive or affective information distortion.

**B1-2:** These individuals also show good balance between the use of cognition and affect information, but are slightly more inhibited in relation to negative affect compared with those in the B3 strategy.

**B4-5:** In contrast to B1-2, individuals assigned to B4-5 will exaggerate negative affect a bit, but are still essentially balanced.

**A1-2:** These individuals will place more emphasis on the use of cognitive information. They inhibit their feelings and place danger at a psychological distance to the self.

**A3-4:** Individuals in this category (compulsive care-giving) inhibit negative affect and protect themselves by protecting the attachment figure. In adulthood, they may work in an occupation related to rescuing or caring for others. Compulsively compliant individuals also inhibit negative affect, but protect themselves by adhering
to the attachment figures requests. They are vigilant and anxious, although this is downplayed by individual.

**A5:** Individuals using the compulsively promiscuous strategy avoid genuine intimacy while maintaining human contact. They show false positive affect and protect themselves from rejection by engaging with many people superficially and not getting deeply involved with anyone.

**A6:** Individuals who adopt a compulsively self-reliant strategy also inhibit negative affect. In a more extreme form of self-protection, they rely on solely on themselves. This strategy is available in adolescence; whereby one withdraws from close relationships when they are old enough to look after themselves. Some individuals in this category may function in social context but refrain from any intimacy. Others will struggle to have any interpersonal relationship and withdraw from social contact.

**A7:** Those categorised as delusionally idealizing have had repeated experience with severe and unpredictable danger. They show false positive affect preferring to position their abusive or neglecting caregivers will protect them. The illusion of safety is employed as an extreme strategy to cope with danger when there is little opportunity for alternative strategies to reduce danger. Outwardly, the individual will show little sign of fear and trauma. Crittenden identifies that this strategy only develops in adulthood.

**A8:** Individuals with an “externally assembled self” strategy are highly compliant and protect themselves by heavy reliance on others, including reliance on others for a sense of self and one's own feelings. The A7 and A8 strategies are seen in individuals exposed to “pervasive and sadistic early abuse and neglect”.

**C1-2:** This threatening-disarming strategy is developed and used in infancy. The individual relies on their feelings to guide behaviour and may exaggerate negative affect to gain the attention of and influence others behaviour, for example, caregiving behaviour (as detailed by Bowlby, 1969). The individual will oscillate between a strong self; blaming others for their problems, and a weak self; luring others in to elicit care-giving behaviour.

**C3-4:** This aggressive-feigned helpless strategy is fully developed in toddlers. The individual oscillates between aggression and helplessness to facilitate compliance from others. When aggressive, compliance is out of fear of attack; when helpless, compliance is out of fear the individual cannot care for themself.
C5-6: This punitive-seductive strategy (obsessed with revenge versus rescue) is an extreme form of C3-4. It begins functioning fully from adolescence. Deception is used for revenge or eliciting rescue behaviours. There is substantial information distortion as the strategies employed move closer to the false cognition side of the circle (see figure 1). This distortion is used to blame others for their situation, and results in increased negative affect. When these strategies are employed, there is a chronic struggle.

Those using C5 appear more distant and self-controlled, forcing others to attend to them. Individuals using C6 appear to need rescuing from danger frequently, but the dangerous situation is often self-induced.

C7-8: The menacing-paranoid strategies are the most extreme Type C, developing in early adulthood. The self-protective strategy is to attack anyone due to the underlying fear of everyone. Focusing primarily on distorted/delusional affect information as an information source, one relies almost solely on their own feelings to assess danger. Revenge is sought against enemies (with information distorted to identify any other as an enemy). Paranoia is thus experienced regarding the identified “enemies”.

A/C: A/C consists of a combination of type A and type C strategies, usually A3/C3 and above (the more information-distorted strategies). Individuals might show very sudden “shifts in behaviour”, as they oscillate between the two categories, attending to false cognition or false affect. In doing so there is a combination of distortion and deception. In its most extreme form an AC strategy would be seen in individuals identified as showing signs of psychopathy; the most severe diagnosis of personality disorder.
APPENDIX D.

Diagnostic criteria for Complex PTSD & Developmental Trauma Disorder.
Diagnostic criteria for complex post-traumatic stress responses

(Luxenberg, Spinazzola & van der Kolk, 2001)

(1) Alteration in Regulation of Affect and Impulses
(A plus one other required)
 a. affect regulation
 b. modulation of anger
 c. self-destructive behaviour
 d. suicidal preoccupation
 e. difficulty modulating sexual involvement
 f. excessive risk-taking

(2) Alterations in Attention or Consciousness
(One required)
 a. amnesia
 b. transient dissociative episodes and depersonalization

(3) Alterations in Self-Perception
(Two required)
 a. ineffectiveness
 b. permanent damage
 c. guilt and responsibility
 d. shame
 e. nobody can understand
 f. minimizing

(4) Alterations in Relations with Others
(One required)
 a. inability to trust
 b. revictimization
 c. victimizing others

(5) Somatization
(Two required)
 a. problems with the digestive system
 b. chronic pain
 c. cardiopulmonary symptoms
 d. conversion symptoms
 e. sexual symptoms

(6) Alterations in Systems of Meaning
(One required)
 a. despair and hopelessness
 b. loss of previously sustaining beliefs
Developmental Trauma Disorder

(van der Kolk, 2005b)

A. Exposure
- Multiple or chronic exposure to one or more forms of developmentally adverse interpersonal trauma (abandonment, betrayal, physical assaults, sexual assaults, threats to bodily integrity, coercive practices, emotional abuse, witnessing violence and death).
- Subjective Experience (rage, betrayal, fear, resignation, defeat, shame).

B. Triggered pattern of repeated dysregulation in response to trauma cues
- Dysregulation (high or low) in presence of cues.
- Changes persist and do not return to baseline; not reduced in intensity by conscious awareness.
  - Affective
  - Somatic (e.g. physiological)
  - Behavioural (e.g. cutting)
  - Cognitive (e.g. dissociation)
  - Relational (e.g. distrustful)
  - Self-attribution (e.g. self-hate)

C. Persistently Altered Attributions and Expectancies
- Negative self-attribution
- Distrust protective caretaker
- Loss of expectancy of protection by others
- Loss of trust in social agencies to protect
- Lack of recourse to social justice/retribution
- Inevitability of future victimization

D. Functional Impairment
- Educational
- Familial
- Peer
- Legal
- Vocational
APPENDIX E.

Crittenden’s theory of parenting.
Table 1. Table summarising Crittenden’s understanding of parenting using the DMM.

<table>
<thead>
<tr>
<th>DISSORTION LEVEL</th>
<th>TYPE</th>
<th>PARENT EXPERIENCE</th>
<th>CHILD EXPERIENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Type A</td>
<td>Over-estimate threat to children</td>
<td>Try to avoid their parent’s attention</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Punishment by the parent is used to teach the child about safe behaviour</td>
<td>Feelings are competence will be heavily dependent on parent’s expression of satisfaction</td>
</tr>
<tr>
<td>Distortions of normal child-protection behaviours</td>
<td></td>
<td>Parents may perceive their behaviour to be protective</td>
<td>Some may overachieve and become successful</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Parents may accept their childhood DR’s without question (what they learned from their own parents)</td>
<td>Others may become fixated on a sense of failure and fear</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tend to mirror own parent’s behaviours.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Type C</td>
<td>Overlook the probability of danger</td>
<td>Heighten their signalling to gain their parent’s attention:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>More likely to under-protect or neglect children</td>
<td>• <em>Exaggerate their affect</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td>May not respond in a timely fashion to children’s needs</td>
<td>• <em>Compete with siblings</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Soothe and comfort children when the child’s arousal has already heightened</td>
<td>• <em>Resort to more extreme behaviours</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Can develop disorders of attention, conduct, and arousal</td>
</tr>
<tr>
<td>Distortions that emphasise self-protective behaviour</td>
<td>Type A</td>
<td>Type C</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>--------</td>
<td>--------</td>
<td></td>
</tr>
<tr>
<td>• Transform desire for comfort into sexual desire</td>
<td>• Reverse the isolating and threatening experiences they may have had in their own childhoods</td>
<td>• May experience confusing affectional bonds to their parents</td>
<td></td>
</tr>
<tr>
<td>• “Affectionate” behaviour towards own children, including sexualised affection Parents under this category are well-attuned to when their child desires comfort</td>
<td>• Satisfaction for the parent (who gets their childhood comfort needs met) and the child (who gets their current comfort needs met)</td>
<td>• May over-attribute their own responsibility in sexual abuse</td>
<td></td>
</tr>
<tr>
<td>• Over-estimate danger to themselves at the expense of protecting children (psychological neglect)</td>
<td>• Focus on their own need for comfort</td>
<td>• Their state does not trigger protection from their parents</td>
<td></td>
</tr>
<tr>
<td>• Focus on their own need for comfort</td>
<td>• Unresolved past trauma or involvement in current adult relationships that creates risk (such as domestic violence)</td>
<td>• Parents will not adapt to meet the child’s needs</td>
<td></td>
</tr>
<tr>
<td>• Unresolved past trauma or involvement in current adult relationships that creates risk (such as domestic violence)</td>
<td>• Experience periods of “psychological absence”</td>
<td>• Some may adopt a parent role (compulsive care-giving)</td>
<td></td>
</tr>
<tr>
<td>• Experience periods of “psychological absence”</td>
<td>• Try to protect the child from knowing about their past/current trauma</td>
<td>• Others may become depressed as they have fewer successful strategies (helplessness)</td>
<td></td>
</tr>
<tr>
<td>• Try to protect the child from knowing about their past/current trauma</td>
<td>• Prevents the child from understanding their parent’s behaviour</td>
<td>• A few may exhibit “autistic” traits, for example, retreating into their own world</td>
<td></td>
</tr>
<tr>
<td>• Prevents the child from understanding their parent’s behaviour</td>
<td>• May position self as child-like and vulnerable and child as powerful</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distortions that substitute delusional information for accurate information</td>
<td>Type A</td>
<td>Type C</td>
<td></td>
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<tr>
<td>---</td>
<td>---</td>
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<td></td>
</tr>
<tr>
<td>• Perceive threats to themselves and their children</td>
<td>• Irrational protective measures</td>
<td>• Child may adopt the role of the parent (also known as &quot;parentification&quot;)</td>
<td></td>
</tr>
<tr>
<td>• Grown up under extreme conditions of threat: associate ordinary conditions with threat</td>
<td>• Might complete compulsive rituals in order to protect self and child</td>
<td>• Find it difficult to develop an integrated sense of self</td>
<td></td>
</tr>
<tr>
<td>• Might be at the expense of meeting the child’s basic needs</td>
<td>• May apply particular rules to caring for their child that puts them at risk</td>
<td>• Repeatedly exposed to their parent’s idea of the child as flawed</td>
<td></td>
</tr>
<tr>
<td>• May isolate themselves from support or heavy reliance on strangers</td>
<td>• Perceive the child to be the source of threat; self as under threat</td>
<td>• Serious risk of harm, both physically and sexually</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Potential attack, abandonment or murder of the child</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• May sexually abuse the child</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Sense of shame and need to “destroy” the child</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Perception of existence as miserable; may murder children to save them from a lifetime of misery</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Perceived or real isolation of the mother</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Isolation enhances perception of self as vulnerable and child as threatening and powerful</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX F.

Tabular summary of quantitative research with mothers diagnosed with BPD.
<table>
<thead>
<tr>
<th>STUDY</th>
<th>FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feldman et al.</td>
<td>(n = 9, Chi-squared or t-test)</td>
</tr>
<tr>
<td>(1995)</td>
<td>Children of mothers diagnosed with BPD were more likely to experience:</td>
</tr>
<tr>
<td></td>
<td>- changes in household composition</td>
</tr>
<tr>
<td></td>
<td>- changes in school</td>
</tr>
<tr>
<td></td>
<td>- exposure to alcohol- and drug-abusing parents</td>
</tr>
<tr>
<td></td>
<td>- exposure to parental suicide attempts</td>
</tr>
<tr>
<td></td>
<td>- exposure to more disruptive and unstable households</td>
</tr>
<tr>
<td></td>
<td>- to exhibit symptoms of BPD during childhood</td>
</tr>
<tr>
<td>Crandell et al.</td>
<td>(n = 8, t-test)</td>
</tr>
<tr>
<td>(2003)</td>
<td>Infants with mothers with BPD showed increased looking away and dazed looks</td>
</tr>
<tr>
<td></td>
<td>- Mother-infant interactions were less satisfying</td>
</tr>
<tr>
<td></td>
<td>- Infants showed dazed looks and lowering of affect</td>
</tr>
<tr>
<td>Hobson et al.,</td>
<td>(n = 10, t-test)</td>
</tr>
<tr>
<td>(2005)</td>
<td>- &quot;Intrusively insensitive&quot; toward their infants</td>
</tr>
<tr>
<td></td>
<td>- Lower levels of &quot;availability for positive engagement&quot;</td>
</tr>
<tr>
<td></td>
<td>- Lower proportion of positive interpersonally directed looks</td>
</tr>
<tr>
<td></td>
<td>- Infants of mothers with features of BPD were more likely to show a disorganised attachment style (8/10)</td>
</tr>
<tr>
<td>Abela et al. (2005)</td>
<td>(n=140 children, hierarchical regression analyses)</td>
</tr>
<tr>
<td></td>
<td>- Children of mothers diagnosed with BPD presented with an insecure attachment style and excessive reassurance seeking</td>
</tr>
</tbody>
</table>
Newman et al. (2007)  
- (n = 17, parametric and non-parametric tests were conducted, with a Bonferroni correction)  
- Less sensitive in their interactions with their infants  
- Less effective in structuring their infant’s activities  
- Infants of mothers with features of BPD were less responsive to the mother’s attempts to interact  
- Infants of mothers with features of BPD were less willing to engage their mother  
- Mothers self-reported feeling less satisfied, less competent and more distressed in their parenting role  

Perepletchikova, Ansell & Axelrod (2012)  
- (n = 41 mothers of children in care, chi-squared, analysis of covariance, hierarchical logistic regression analysis)  
- Mothers involved with child protection services scored significantly higher on measures of BPD features  
- Highest BPD scores were associated with the most severe histories of mothers’ childhood maltreatment  
- BPD features rather than maltreatment history predicted maternal involvement with child protection services  

Hobson, Patrick, Hobson, et al. (2009)  
- (n = 13, no statistical test)  
- Mothers showed disrupted affective communication  
- Mothers showed frightened/disoriented behaviour  

Macfie & Swann (2009)  
- (n = 30 children whose mothers had BPD, narrative coding systems)  
- Children whose mothers have BPD told stories in which:  
  - the caregiver–child relationship was characterized by more role reversal  
  - there was more fear of abandonment  
  - there were more negative mother–child and father–child relationship expectations  
  - the self was represented as more incongruent and shameful
APPENDIX G.

Ethical approval paperwork.
Dear Miss Rogers

The Research Ethics Committee reviewed the above application at the meeting held on 14 March 2012. Thank you for attending to discuss the study.

1. The Committee asked you to include in the PIS and in the Consent form that questions raised in the interview will be about their experience of parenting and being parented.

You agreed to amend the PIS and Consent form accordingly.

2. The Committee asked for clarification on what age category is meant by "parents with school-aged children" as stated in Question A6-2.

You clarified that it meant adults (under 18 years old) but not pre-school ages.

3. The Committee asked you what precautions are in place in the event the participant becomes distressed.

You explained that if a question was too upsetting or too personal then the interview could be stopped and the participant could choose to end the interview. You added that you would set-aside time to talk with the participant and offer support and if need be offer help through the SUN project.

4. The Committee sought clarification from you regarding the minimum criteria needed in order to self-identify with the features of borderline personality disorder.

You explained that there is guidance available on how to self-identify, however participants who are recruited for this research study will have already been identified beforehand through the SUN project which is a service specifically for individuals who identify with the diagnosis of personality disorder. You added that the SUN project does

A Research Ethics Committee established by the Health Research Authority
not diagnose patients.

5. The Committee requested that you submit a standard Consent form. Details of the correct Consent template can be found on the IRAS website.

You agreed to re-submit the Consent form using the correct standard format.

6. The Committee asked for the correct REC (City Road and Hampstead) to be put on the PIS.

7. The Committee felt that "mental health staff do not understand and do not treat patients well" should be re-worded in the PIS and asked you if you intended to mean this.

You explained that this was based on research conducted and was widely recognised, however you appreciated how this message could be construed negatively and agreed to re-word it appropriately.

8. The Committee recommended that under the section "Are there any downsides of taking part?" of the PIS the wording should be re-phrased to be more direct and black and white. The Committee felt that if the participant does feel that the topic of parenting would be too distressing then the participant should be advised not to partake in the study, not "take time to consider whether it would be a good idea" as stated in the PIS.

You agreed to re-word this appropriately.

Ethical Opinion

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

1. Please include in the PIS and in the Consent form that questions raised in the interview will be about their experience of parenting and being parented.

2. The Committee requested that you please submit a standard Consent form. (N.B. Details of the correct Consent template can be found on the IRAS website: www.nres.nhs.uk)

3. The Committee asked for the correct REC Committee name (City Road and Hampstead) to be put on the PIS please.

4. The PIS states that mental health staff do not understand/give a poor diagnosis of the condition and do not treat patients well; this should be re-worded appropriately to avoid this message being misconstrued in a negatively way please.

5. The Committee asked for the wording in the PIS, under the section titled "Are there any downsides of taking part?" to be re-phrased to be more direct and black and white for the participant reading it.

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).
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 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).

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Confirmation should also be provided to host organisations together with relevant documentation.

Approved documents

The documents reviewed and approved at the meeting were:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covering Letter</td>
<td></td>
<td>13 February 2012</td>
</tr>
<tr>
<td>Evidence of insurance or indemnity</td>
<td></td>
<td>10 February 2012</td>
</tr>
<tr>
<td>Interview Schedules/Topic Guides</td>
<td>1</td>
<td>10 February 2012</td>
</tr>
<tr>
<td>Investigator CV</td>
<td></td>
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<tr>
<td>Other: Academic Supervisor Arlene Vetere CV</td>
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<td></td>
</tr>
<tr>
<td>Participant Consent Form</td>
<td>1</td>
<td>10 February 2012</td>
</tr>
<tr>
<td>Participant Information Sheet</td>
<td>1</td>
<td>10 December 2012</td>
</tr>
<tr>
<td>REC application</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referees or other scientific critique report</td>
<td></td>
<td>26 January 2012</td>
</tr>
</tbody>
</table>

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

There was no declaration of interest.

Statement of compliance
The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

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
- Notification of serious breaches of the protocol
- 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.

Feedback

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.

Further information is available at National Research Ethics Service website > After Review

12/LO/0359 Please quote this number on all correspondence

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

Yours sincerely,

Dr David Slovick
Chair

Email: uh-tr.riversiderc@nhs.net

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments

"After ethical review - guidance for researchers" via email

Copy to: Professor Arlene Vetere, University of Surrey
Ms Enitan Eboda, South West London And St George's Mental Health NHS Trust
NRES Committee London - City Road & Hampstead

Attendance at Committee meeting on 14 March 2012

Committee Members:

<table>
<thead>
<tr>
<th>Name</th>
<th>Profession</th>
<th>Present</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Koula A. Asimakopoulou</td>
<td>Senior Lecturer in Health Psychology</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Ms Jill Bloom</td>
<td>Drug Information Pharmacist</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Mrs Stephanie Cooper</td>
<td>Solicitor</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Mrs Ros Goldfarb</td>
<td>Retired Immigration Judge</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Mr Robert Goldstein</td>
<td>Economist</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Mr Hari Jayaram</td>
<td>Academic Clinical Lecturer in Ophthalmology</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Mr Peter Jones</td>
<td>Retired Head teacher</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Dr Stella Kingett</td>
<td>Consultant Psychiatrist</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Professor Diana Kombrot</td>
<td>Professor of Mathematical Psychology</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Ms Sanaa Mehdipour</td>
<td>Senior Dealer Treasury Specialist</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Mr Israel Nartey</td>
<td>Associate Specialist/Lead Clinician-Ophthalmology</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Miss Tobie Patterson</td>
<td>Diabetes Team Member</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Ms Mary Ryan</td>
<td>Personnel Manager</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Dr David Slovick</td>
<td>Consultant Physician</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

Also in attendance:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position (or reason for attending)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miss Charlotte Allen</td>
<td>Coordinator</td>
</tr>
<tr>
<td>Miss Tina Cavaliere</td>
<td>Coordinator</td>
</tr>
</tbody>
</table>
30 April 2012

Miss Bertha Rogers
University of Surrey
Department of Psychology
Guildford
GU2 7XH

Dear Miss Rogers

Full title of study: The experience of parenting and being parented for mothers who identify with the features of borderline personality disorder: an interpretative phenomenological analysis.

REC reference number: 12/LO/0359
Protocol number: N/A
EudraCT number: N/A

Thank you for your letter dated 17th April 2012. I can confirm the REC has received the documents listed below as evidence of compliance with the approval conditions detailed in our letter dated 14 March 2012. Please note these documents are for information only and have not been reviewed by the committee.

Documents received

The documents received were as follows:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covering Letter</td>
<td>N/A</td>
<td>17 April 2012</td>
</tr>
<tr>
<td>Participant Consent Form</td>
<td>2</td>
<td>17 April 2012</td>
</tr>
<tr>
<td>Participant Information Sheet</td>
<td>2</td>
<td>17 April 2012</td>
</tr>
</tbody>
</table>

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

12/LO/0359 Please quote this number on all correspondence

Yours sincerely

Miss Christine Hobson
Committee Co-ordinator

E-mail: christinehobson@nhs.net

Copy to: Professor Arlene Vetere, University of Surrey
Ms Enitan Eboda, South West London And St George's Mental Health NHS Trust
11th May 2012

Dear Bertha

Reference: 766-PSY-12 (NHS Approved)
Title of Project: The experience of parenting and being parented for mothers who identify with the features of borderline personality disorder: an interpretative phenomenological analysis.

Thank you for your submission of the above proposal.

The Faculty of Arts and Human Sciences Ethics Committee has now given a favourable ethical opinion.

If there are any significant changes to your proposal which require further scrutiny, please contact the Faculty Ethics Committee before proceeding with your Project.

Yours sincerely

Dr Adrian Coyle
Chair

Dr Adrian Coyle
Chair: Faculty of Arts and Human Sciences Ethics Committee
University of Surrey

Bertha Rogers
Trainee Clinical Psychologist
School of Psychology
University of Surrey
Dear Bertha,

Research Title: The experience of parenting and being parented for mothers who identify with the features of borderline personality disorder: an interpretative phenomenological analysis.

Principal Investigator: Miss Bertha Rogers
Project reference: PF521
Sponsor: University of Surrey

Following various discussions your study has now been awarded research approval. Please remember to quote the above project reference number on any future correspondence relating to this study.

Please note that, in addition to ensuring that the dignity, safety and well-being of participants are given priority at all times by the research team, host site approval is subject to the following conditions:

In addition to ensuring that the dignity, safety and well-being of participants are given priority at all times by the research team, you need to ensure the following:

- The Principal Investigator (PI) must ensure compliance with the research protocol and advise the host of any change(s) (eg. patient recruitment or funding) by following the agreed procedures for notification of amendments. Failure to comply may result in immediate withdrawal of host site approval.

- Under the terms of the Research Governance Framework, the PI is obliged to report any adverse events to the Research Office, as well as the REC, in line with the protocol and sponsor requirements. Adverse events must also be reported in accordance with the Trust Accident/Incident Reporting Procedures.

- The PI must ensure appropriate procedures are in place to action urgent safety measures.

- The PI must ensure the maintenance of a Trial Master File (TMF).

Terms and conditions of Approval, version 1.1 13/06/2012
The PI must ensure that all named staff are compliant with the Data Protection Act, Human Tissue Act 2005, Mental Capacity Act 2005 and all other statutory guidance and legislation (where applicable).

The PI must comply with the Trust's research auditing and monitoring processes. All investigators involved in ongoing research may be subject to a Trust audit and may be sent an interim project review form to facilitate monitoring of research activity.

The PI must report any cases of suspected research misconduct and fraud to the Research Office.

The PI must provide an annual report to the Research Office for all research involving NHS patients, Trust and resources. The PI must also notify the Research Office of any presentations of such research at scientific or professional meetings, or on the event of papers being published and any direct or indirect impacts on patient care. This is vital to ensure the quality and output of the research for your project and the Trust as a whole.

Patient contact: Only trained or supervised researchers holding a Trust/NHS contract (honorary or substantive) will be allowed to make contact with patients.

Informed consent: is obtained by the lead or trained researcher according to the requirements of the Research Ethics Committee. The original signed consent form should be kept on file. Informed consent will be monitored by the Trust at intervals and you will be required to provide relevant information.

Closure Form: On completion of your project a closure form will be sent to you (according to the end date specified on the R & D database), which needs to be returned to the Research Office.

All research carried out within South West London & St George's Mental Health NHS Trust must be in accordance with the principles set out in the Department of Health’s Research Governance Framework for Health and Social Care 2005 (2nd edition).

Failure to comply with the conditions and regulations outlined above constitutes research misconduct and the Research Office will take appropriate action immediately.

Please note, however, that this list is by no means exhaustive and remains subject to change in response to new relevant statutory policy and guidance. If you have any queries regarding the above points please contact me on 020 8725 3463 (St. George's), e-mail: eeboda@squl.ac.uk.

Yours sincerely,

Enitan Eboda (Ms)
Research & Development Co-ordinator
On behalf of the Research & Development Committee.

Terms and conditions of Approval, version 1.1 13/06/2012
11 January 2013

Miss Bertha Rogers
University of Surrey
Department of Psychology
Guildford
GU2 7XH

Dear Miss Rogers

The experience of parenting and being parented for mothers who identify with the features of borderline personality disorder: an interpretative phenomenological analysis.

REC reference: 12LO/0359
Protocol number: N/A
Amendment number: 2
Amendment date: 07 January 2013
IRAS project ID: 91618

The above amendment was reviewed at the meeting of the Sub-Committee hold on 08 January 2013 by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protocol</td>
<td>4 - Clean</td>
<td>04 December 2012</td>
</tr>
<tr>
<td>Notice of Substantial Amendment (non-CTIMPs)</td>
<td></td>
<td>07 January 2013</td>
</tr>
<tr>
<td>Protocol</td>
<td>4 - Tracked</td>
<td>04 December 2012</td>
</tr>
</tbody>
</table>
Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

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

We are pleased to welcome researchers and R&D staff at our NRES committee members' training days — see details at http://www.hra.nhs.uk/hra-training/

Yours sincerely

Mr Hari Jayaram
Vice Chair

E-mail: nrescommittee.london-cityroadandhamptestd@nhs.net

Enclosures: List of names and professions of members who took part in the review

Copy to: Ms Enitan Eboda, South West London And St George's Mental Health NHS Trust
Professor Arlene Vetere, University of Surrey

A Research Ethics Committee established by the Health Research Authority
Dear Bertha,

Research Title: The experience of parenting and being parented for mothers who identify with the features of borderline personality disorder: an interpretative phenomenological analysis.

Principal Investigator: Miss Bertha Rogers
Project reference: PF521
Sponsor: University of Surrey

Thank you for your e-mails of 20th September and 17th November 2012, in which you outlined amendments to your previously approved proposal (ref. PF521).

I can confirm that I do not have any objections to the amendment to your study, since you have gone through the correct channels to seek approval from the relevant bodies. You may therefore accept this letter as official notification, on behalf of the R&D Committee, that the amendment has been accepted and the terms of R&D approval originally stated in my letter of 13th June 2012 still apply.

Please note, however, that this list is by no means exhaustive and remains subject to change in response to new relevant statutory policy and guidance. If you have any queries regarding the above points please contact me on 020 8725 3463 (St. George's), e-mail: eeboda@saul.ac.uk.

Yours sincerely,

Enitan Eboda (Ms)
Research & Development Co-ordinator
On behalf of the Research & Development Committee.

Terms and conditions of Approval, version 1.1 20/11/2012
Dear Bertha

Re: The experience of parenting and being parented for mothers who identify with the features of borderline personality disorder: an interpretative phenomenological analysis

SABP Ref: SBP164
REC Ref: 12/LO/0369

Thank you for submitting all the required documentation relating to the above study for Trust R&D approval.

The above study has full Trust approval. The approval granted relates only to the specific protocol V4 dated 04 December 2012, the attachments and the signed Expression of Interest form for this Trust. Any deviation from these documents will be deemed to invalidate this approval. The study must be conducted according to the Department of Health Research Governance Framework for Health and Social Care at http://www.dh.gov.uk. All material accessed in the Trust must be treated in accordance with the Data Protection Act (1998), The NHS Code of Confidentiality and Caldicott Principals.

Condition:
The Research Agreement must be signed and returned to SABP. Failure to do so could result in withdrawn of this approval letter.

Responsibilities:
It is the responsibility of the Chief Investigators to ensure that the study is carried out in accordance with the protocol and the National Research Ethics Service (NRES) approval. Amendments, including extending the project to other Trust sites, may require further approval. All amendments should be submitted following NRES procedures and copies, including the favourable opinion, sent to the Trust R&D Office.

The sponsor and/or the principal investigator must take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety. Notification of any such action must be submitted to the relevant authorities and the R&D Office as agreed in the letter of agreement between the sponsor and the Trust.
The project must be completed within the timescale as set out in the Ethics application. If the project continues out of the timescale agreed, new permission(s) must be sort and obtained.

The Chief Investigator is to comply with the monitoring arrangements of the Trust by submitting quarterly reports; a template will be sent to you for your records. All publications relating to the study, and a final report for this project to be sent to the Trust’s R&D Office. Kindly also submit a copy of the end of project notification submitted to NRES.

All external researchers who seek access to the Trust in relation to this study will need to obtain an honorary research contract by submitting a research passport, if appropriate, and be issued with a SABP letter of access before entering Trust premises. Researchers who have a contractual relationship with an NHS body should submit the relevant documentation and request a NHS to NHS letter of access. Applications can be accessed on: http://www.ukcfc.on3/reaulatiortaovemaoce/researchpassport/

All parties to familiarise themselves and comply with Trust R&D policies and procedures, available on the Trust website: http://www.sabp.nhs.uk/aboutus/policies-and-procedures?searchterm=POLICIES

Failure to comply with any of the above may result in withdrawal of Trust approval.

Please do not hesitate to contact me if you wish to discuss any aspect of this approval.

I wish you well with your study.

Yours Truly

Dorrie Mystris
R&D Facilitator
On behalf of the R&D Team

Cc: Melanie Orchard – SABP Clinical Psychologist
Prof. Arlene Vetere, University of Surrey - a.vetere@surrey.ac.uk
APPENDIX H.

Participant information sheet.
Participant Information Sheet.

Title of Project: The experience of parenting and being parented for mothers who identify with the features of Borderline Personality Disorder.

Name of Researcher: Miss Bertha Rogers

My name is Bertha Rogers and I am a trainee clinical psychologist, training at the University of Surrey, based in Guildford. As part of my training I do work placements in South West London and St. Georges NHS Trust. Part of my training also requires undertaking a piece of research. I have chosen to research the parenting experiences for mothers with features of Borderline Personality Disorder. The following information will help you understand why the research is being done, and what will be involved if you decide to take part.

What is the study about?
I am researching the parenting experience of mothers who identify with the diagnosis of Borderline Personality Disorder, focusing on how they were parented as a child and how they parent their own children now. I am also interested in finding out how mothers with features of Borderline Personality Disorder think their difficulties impact on their parenting abilities, and any support they may access. I would be grateful if you would help me with this by taking part in my study. You do not have to have received a formal diagnosis of Borderline Personality Disorder, as long as you identify with the features of the diagnosis:

- Fear of abandonment
- Unstable/intense relationships
- Unstable sense of self
- Impulsivity
- Recurrent suicidal/self-harming behaviour
- Frequent changes in emotion
- Difficulty controlling anger
- Chronic feelings of emptiness
- Stress-related paranoia or dissociative symptoms

Why is this research being done?
Staff working in mental health settings may have little training on Borderline Personality Disorder, which can lead to a poor understanding of the diagnosis. By carrying out research with people with features of Borderline Personality Disorder we can help staff to better understand the perspective of individuals that experience the difficulties associated with Borderline Personality Disorder. At present, research with this population has focused on their experience of receiving/understanding of the diagnosis. However, I would like to focus
specifically on mothers who experience the difficulties associated with this diagnosis to help develop understanding of and future services for mothers with features of Borderline Personality Disorder.

**What will I have to do?**
You will be asked to complete an interview with me in a private room at Springfield hospital. When we meet you will be asked to sign a Consent Form, to say that you have understood the research you are involved in, and to confirm you have had the opportunity to ask me any questions you have about the research. The Consent Form also says that all information about you is kept confidential in accordance with the Data Protection Act 1998. I will have some pre-prepared topic areas that I will want to ask you during the interview, but you are not restricted to talk only about the areas I ask you (as long as it is relevant to the topic of parenting). The interview length will vary depending on how much you want to share about your experiences, but the maximum length would be around two hours. You are able to take a break during the interview, or end the interview, at any time. To ensure my understanding of your experiences is accurate I will record the interview and type up the interview word-for-word when it has ended. You will be reimbursed for any travel expenses incurred in order to travel to the interview, plus £13 to reimburse for the time taken to travel to and participate in the interview.

**Do I have to take part?**
No, taking part in this study is entirely up to you. You are welcome to discuss taking part in this research with friends, family, The SUN project group/staff, etc. You can also contact me for further information, or to discuss the research, and I would be happy to answer any queries. My contact details are at the end of this information sheet. Whether or not you decide to take part in this research, your decision will have no effect on any care or treatment you are receiving. If you agree to take part, you can choose not to answer any of the questions during the interview and you can withdraw from the research if you change your mind at any time up to the point that the research is submitted for assessment, September 2013 without giving a reason.

**How do I agree to take part?**
You can contact me at the details given at the end of this sheet, or contact the SUN project, who can contact me on your behalf. You can also contact me to ask any questions before agreeing to take part. If you are interested in taking part I will contact you via telephone to arrange a meeting at Springfield hospital at a time/date convenient for you.

**Does what I say get shared with anyone else?**
As a trainee, my research project is supervised by two senior professionals (including Dr. Stephen Miller from the SUN project), so my research supervisors may have access to the
information about you during the research study. Supervision is required to ensure I am correctly conducting the research, and to raise any issues of risk that may arise during the interview. In this instance I would first inform you that I will be discussing this issue with my supervisor. Once I have discussed this with my supervisor and we have decided on the next steps (if any) you would be informed whether we were required to inform any other professionals or were taking further action with this information. My supervisors' name and contact details are at the end.

Your name and all personal details about you will be kept anonymous in the research study. If this research is published I will include collective information, for example, the age range, or ethnic group, of participants. However, no information that could personally identify you will be included. All information gathered during this research study will be stored securely in a locked filing cabinet at the University of Surrey, in accordance with the Data Protection Act 1998 and will be destroyed after ten years. Audio recordings will be destroyed five years after the research has been disseminated.

What happens when the research study is completed?
At the end of the research project my supervisors and I hope to publish the findings of this research. As I mentioned previously, personal details will not be offered in this publication, with age and ethnicity information published as a group, rather than individuals. If you decide to take part and would like a copy of the research report, I can send you a copy of the final research study plus copies of any articles published based on the research. This piece of research will be completed by September 2013.

What are the benefits of taking part?
The research may not benefit you directly. It will provide an opportunity for you to talk about and reflect on your experiences of being parented, and your experiences of being a parent, which can be helpful for some individuals. The main benefit of taking part is contributing to an area of research which could inform mental health services, particularly for mothers with features of Borderline Personality Disorder.

Are there any downsides of taking part?
As the research asks about your personal experiences you may find some of the questions personal and possibly upsetting. If you find a question too personal or upsetting in any way, you don't have to answer it. We can also take a break at any time during the interview or you can decide to end the interview if you do not want to continue. If you do find the experience upsetting and you would like some support, then I can spend some time afterwards with you or you can receive support through The SUN project. If you think the topic of parenting would be too upsetting to discuss it is advised you do not take part in the study.
What if there is a problem?
If you have any concerns about any aspect of the way you have been treated during the course of the research study, then you can contact one of my supervisors. Their names are Dr. Stephen Miller and Prof. Arlene Vetere. Their contact details are included at the end of this information sheet.

Has the research been approved by any committee?
The study has been approved by the Faculty of Arts & Human Sciences at the University of Surrey Ethics Committee and also the Research Ethics Committee for City Road & Hampstead.

I hope this answers any questions/concerns you had about the research. If there is anything you would like to know please contact me, using the details given below.

Thank you for your time.

This research is being conducted by:
Bertha Rogers

Supervised by:
Prof. Arlene Vetere

Dr. Stephen Miller
APPENDIX I.

Charity internet advert.
Are you a mother? Do you identify with the features or diagnosis of Borderline Personality Disorder?

Staff working in mental health settings may have little training on Borderline Personality Disorder, which can lead to a poor understanding of the diagnosis. Research on staff attitudes towards this diagnosis has suggested that there is a risk of stigma against these individuals, especially those who are in a parenting role. Previous research on mothers with Borderline Personality Disorder has focused on how they interact with their children, yet there is no research on their own experience of being a mother.

The University of Surrey would like to focus specifically on mothers who experience the difficulties associated with this diagnosis to help develop understanding of and future services for mothers with features of Borderline Personality Disorder. The interview will take around one hour and will focus on the individual’s experiences of being parented and how they go on to parent their own children. Any travel expenses incurred will be reimbursed as well as an additional £13 for time taken to attend the interview. If you would be interested in learning more about this research and/or would like to take part please contact Bertha Rogers at b.l.rogers@surrey.ac.uk or on 07973 690 324.

This study is being conducted as part of a Doctoral Thesis in Clinical Psychology. The study has been granted a favourable ethical opinion by the ethics committee of the Faculty of Arts and Human Sciences at the University of Surrey.
APPENDIX J.

Interview schedule.
The interview schedule will generally focus on past experiences of parenting and participants’ current experience of being a parent. The interview schedule will be based on, but not restricted to:

- A discussion on the participant's early relationship with their parents.
  - Who was in the household growing up?
  - Describe relationships
  - Memories
  - Other significant relationships

- A discussion on the participant's current relationship/s with their own child/ren.
  - Who is in household now?
  - Describe relationships
  - Examples
  - Links to own parent’s parenting style

- A discussion on how the features of BPD the participant believes they have impacts on the way you parent
  - Positives and negatives

- A discussion of the resources (if any) the individual makes use of in relation to parenting
APPENDIX K.

Table detailing participant information.
Table 3. Participant information.

<table>
<thead>
<tr>
<th>NAME</th>
<th>AGE</th>
<th>ETHNIC ORIGIN</th>
<th>DIAGNOSED AFTER CHILD</th>
<th>NO. OF CHILDREN</th>
<th>EARLY HOME ENVIRONMENT</th>
<th>CURRENT HOME ENVIRONMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Katherine</td>
<td>Early sixties</td>
<td>White British</td>
<td>Yes</td>
<td>3</td>
<td>Mother, father (left aged ten), three younger sisters</td>
<td>Living alone, divorced twice, two sons and one daughter (adult children)</td>
</tr>
<tr>
<td>Jasmine</td>
<td>Late forties</td>
<td>White Other</td>
<td>Yes</td>
<td>2</td>
<td>Adoptive mother and father, two younger sisters (parent's biological children)</td>
<td>Living alone, divorced twice, one son (living with father) and one daughter (currently looked after)</td>
</tr>
<tr>
<td>Hayley</td>
<td>Early thirties</td>
<td>White Other</td>
<td>Yes</td>
<td>1</td>
<td>Mother, father, one younger sister</td>
<td>Living with one daughter, divorced twice</td>
</tr>
<tr>
<td>Charlotte</td>
<td>Mid-twenties</td>
<td>White British</td>
<td>No</td>
<td>1</td>
<td>Mother, father, one younger brother</td>
<td>Living with partner and one son</td>
</tr>
<tr>
<td>Stacey</td>
<td>Early fifties</td>
<td>White British</td>
<td>Yes</td>
<td>2</td>
<td>Mother, father (died age ten), then step-father, only child</td>
<td>Living with partner, divorced from children's father, one daughter and one son (adult children)</td>
</tr>
<tr>
<td>Leyla</td>
<td>Early forties</td>
<td>Black British</td>
<td>Yes</td>
<td>3</td>
<td>Raised by neighbours, moved to another country with grandparents then moved in with mother (both pre-adolescence)</td>
<td>Living with two daughters, divorced twice, two daughters and one son (two adult children)</td>
</tr>
<tr>
<td>Patricia</td>
<td>Early thirties</td>
<td>White British</td>
<td>Yes</td>
<td>1</td>
<td>Mother, father, two younger sisters</td>
<td>Living with husband and one son</td>
</tr>
<tr>
<td>Sienna</td>
<td>Late thirties</td>
<td>Black British</td>
<td>Yes</td>
<td>1</td>
<td>Mother, dad left family home (Sienna age 5), younger half-sister and half-brother</td>
<td>Living with one daughter, divorced</td>
</tr>
<tr>
<td>Katie</td>
<td>Late forties</td>
<td>White British</td>
<td>Yes</td>
<td>1</td>
<td>Father, mother left family home (Katie age 4), brother and sister</td>
<td>Living alone, divorced, one son (living with father)</td>
</tr>
</tbody>
</table>

10 Pseudonym given to participant to protect identity.
APPENDIX L.

Participant consent form.
Title of Project: The experience of parenting and being parented for mothers who identify with the features of Borderline Personality Disorder.

Name of Researcher: Miss Bertha Rogers

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

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

3. I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from South West London & St Georges NHS Trust, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

4. I agree to my GP being informed of my participation in the study.

5. I agree to take part in the above study.

Name of Patient Date Signature

Name of Person Date Signature taking consent

When completed: 1 for participant; 1 for researcher site file; 1 (original) to be kept in medical notes.
Interviewer (BR): So just to confirm before we start that you've read the information sheet.

Interviewee (PI): Yeah.

BR: -and signed the consent form saying you agree to take part.

PI: Yeah, I have.

BR: Okay. So to start off with—we'll start the first part of the interview asking about your early experiences and then move on to what it's like being a parent yourself. So to start off with, who would—

— who was in your household growing up?

PI: Erm, my mum and dad and there were three sisters and I was the eldest. But erm it was like world war three with my mum and dad, they were always rowing and fighting. My dad would leave home and then come back again, and every time he came back my mum got pregnant. And erm he eventually left when I was ten years old. But erm... where they were constantly... well the way I put it... when they weren't fighting, they were fucking. That's how I saw it as a little girl, d'you know what I mean?

BR: Mmm.

PI: And I was on Phenobarbital at three years old cause I had such bad anxiety and er I was dad's favourite which didn't help as far as my mum was concerned — I suffered being dad's favourite because erm... the difference is my baby sister came along when I was ten years old. The second one came along when I was two, the third one came along when I was four, and the baby— came along when I was ten. So there was four girls. And erm, the little one, the baby, has been the apple of my mum's eye. The three older girls got pushed out quite a bit. Sorry, go on.

BR: No, I was going to say, so you were dad's favourite—

PI: Yeah and he made it worse 'cause he'd buy me things — like when it was my fifth birthday he bought me a bike but he didn't the other girls. And then when I was seven and could tell the time he bought me a watch and... my mum just hated it. But erm...

BR: Other than your dad buying you things how else did he show you, you were his favourite?

PI: Well he was never hardly there, he just- with my mum there was never any kissing or cuddling or anything like that. The only time she ever touched me is when I was really little and having a bath. She

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married eventually again. But erm... it didn't last long — he died of a blood clot in his lung and I think it was god paying him back.

BR: Paying him back for?

PI: Not treating us right.

BR: Okay. You said about — before your dad left — them arguing a lot. What sort of things- Do you remember what they used to argue about?

PI: I can't remember all of it now— they were just constant bickering d'you know what I mean. She didn't like him going out— she didn't like him going out but she used to wash and have his clothes all laid out for him to go out... like if he was back late from the pub of a Sunday there would be uproar 'cause dinner had been dished up. It was just general bickering, but she kept taking him back but... she despised him for what he done but I think to myself did she despise herself for taking him back.

BR: Why do you think she took him back if she despised him?

PI: She said she never loved him but I know she did— she did love him.

BR: Where would the children be when they were arguing?

PI: Oh we were always — we always had to go to bed at six o'clock.

BR: Very early...

PI: Yeah and I — I used to be worried that— well I knew he'd gone out anyway or he'd be at work— and I used to be calling downstairs all the time "nun night mum", "are you still there?" and she wouldn't answer sometimes to make me think she'd gone out and left us.

BR: That sounds really scary when you're a child.

PI: Yeah she was erm... she... To me— I might have the wrong opinion— but I always felt she was trying to torture me mentally. And my dad used to shout at her over it like... I was only a little dot and I recall vividly erm I said what have we got for dinner tonight mum? And she said'air pie and windy pudding', which is nothing is it? But the little kid thought she's gonna cut my hair off and put it in a dish 'cause I knew what a bitch she was — young!

BR: So you thought she meant a hair pie?
APPENDIX N.

Table of themes.
Table 4. Audit trail from data to master themes.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-themes</th>
<th>Grouping across participant</th>
<th>Quotes</th>
</tr>
</thead>
</table>
| 1. Signs of anxiety/low mood in childhood due to early adverse experiences | Signs of anxiety showing from an early age | • Experiencing anxiety from an early age (Katherine)  
• Describing childhood as happy but early signs of anxiety running through it (Jasmine)  
• Mum was unsure when to get me help when depression and anxiety were showing from an early age (Charlotte)  
• I was showing signs of distress as a child but no one seemed to do anything (Leyla)  
• Anxiety due to step-father’s behaviour (Stacey) | • Scholarism was erm cherished and prized and in order to be a scholar one has to study, and I used to get very anxious and I LOVED history- absolutely loved it, but exams, I couldn’t do exams- I used to get so anxious. I had to cram for this exam even though I knew it, but the exam was the following day, and I remember getting my first ever panic attack… if I get good grades then mum will approve of me, that I’m a good girl (Jasmine)  
• My mum and dad owned two restaurants so I never really saw them, I only really saw the au pairs. So I didn’t really have a relationship with them until I was eleven when we moved… mum did say- well she says now that- that I was showing signs of depression but she just never thought of getting me any help… when I was like nine (Charlotte)  
• The thing is I used to pick, I used to steal, you know, my behaviour- I look at people when they- people must have seen things in me or heard me say things that made them want to things – think that I didn’t wanna go home, think that- you know, why would you ask for me to come and live with you if you thought everything was great? D’you know what I mean? I can’t remember it for myself, if that makes sense; I’m almost scared to ask my mum like “what was going on for me? What was I really- what- what was I like as this kind of teenager with you? ’Cause I obviously wasn’t happy. (Leyla) |
<table>
<thead>
<tr>
<th>1. Signs of anxiety/low mood in childhood due to early adverse experiences</th>
<th>Am I the way I am because of genetics or my early experiences?</th>
<th>I hate my mum for the way I am (Katherine)</th>
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<td></td>
<td></td>
<td>Decision to stop speaking to mother over the way she raised me (Hayley)</td>
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<td>Understanding why I went crazy; my fault or my parents? (Charlotte)</td>
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<td>Seeking an explanation for why I am the way I am – Is it my brain? Do I have Asperger's? (Jasmine)</td>
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<td>Why did I become the way I am? (Stacey)</td>
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<td>I'm trying to understand why I am like I am but mum won't accept responsibility (Leyla)</td>
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<td>I hate [mum] for the way I've turned out... I often think now what sort of person would I have been if I hadn't had all this shit with my mum and dad. And there was brains to start off with once my dad left home I went into the seniors that year and everything went to pot. Couldn't concentrate anymore, didn't sit no exams. I just became a babysitter d'you know what I mean (Katherine)</td>
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<td></td>
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<td>It's also kind a nature versus nurture kind of thing because all of these symptoms that I well not all of them—a lot of them could go back towards my relationship with my mother, especially yeah, the last point, you know, how much of it is psychological, how much of it is potentially because of brain chemistry. (Hayley)</td>
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<td>[Step-dad] used to drink a lot so he used to argue and fight and be quite violent so we used to have to walk the streets quite a lot... my mum was like erm quite private, she didn't want anyone know, we always had to keep quiet about what was kind of happening at home so I never spoke to anybody about what was actually going on in the home environment in those years (Sienna)</td>
</tr>
<tr>
<td>1. Signs of anxiety/low mood in childhood due to early adverse experiences</td>
<td>Significant events that led to getting “ill” or going “crazy” by humiliation, loss or abuse</td>
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<td>• All hell broke loose after being bullied (“getting ill”) (Jasmine)</td>
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<td>• Bodily responses to the traumatic experiences (Katherine)</td>
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<td>• Being bullied in primary school; called a liar by school and bullying got worse (Charlotte)</td>
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<td>• Significant traumas experienced in childhood: losing dad and spending time in hospital (Stacey)</td>
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<td>• Mum’s remarried and he was physically abusive and intrusive (Stacey)</td>
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<td>• Daughter is the age I was when sexually abused so I face the reality that it was abuse (Leyla)</td>
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<td>• I want to be liked by others so I end up in unhelpful and unhappy relationships (Leyla)</td>
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<td>• Significant losses in childhood including my siblings, my Nan and my school (Charlotte)</td>
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<td>• Usually have one close friend/relationship; hard time when that ends (Hayley)</td>
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<td>• It was like world war three with my mum and dad; they were always rowing and fighting... My dad would leave home and then come back again, and every time he came back my mum got pregnant. And erm he eventually left when I was ten years old (Katherine)</td>
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<td>• I took an overdose two days after my birthday... I always get... suicidal on my birthday (laughs) ‘cause of the brother and sister thing [one of triplets], ‘cause they died I feel like I should die... I had my Nan who I was quite close to but then she died when I was nine and then I had- I had my-that’s when I had my first panic attack (Charlotte)</td>
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<td>• I was quite lonely... when I was eleven I worked at a riding stable and the owner of the riding stables was forty-six and I had a sexual relationship with him from eleven to sixteen, and it’s really because - psychiatrists and stuff say that’s sexual abuse but I don’t see it that way because it’s something I wanted to do, so it’s hard. So I virtually every day at the stables... so I was quite detached from the family in that respect (Katie)</td>
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<td>• My dad was a miner and then erm, he was taken ill he had a few heart attacks, and then in nineteen-seventy erm I was ten I went into hospital, I had Osteomyelitis in both legs and I was in for four months er and then I came out in the December and I think it was like the shock of it was a bit too much for him and he died in the February, so just left the three of us. It was just weird ‘cause I think at that age you don’t know how to grieve for someone, and it didn’t hit me until much, much later on that I needed my dad then you know and in the meantime then my mum got remarried, a couple of years later... (Starts to cry)... and... he was not nice (Stacey)</td>
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<td>• When I was about eleven, he started sexually abusing me, so I had that kind of up-relationship with him until I was about sixteen, and my brother and sister were born in between that time (Sienna)</td>
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<tr>
<td>• I was quite lonely... when I was eleven I worked at a [work place] and the owner of the [work place] was forty-six and I had a sexual relationship with him from eleven to sixteen, and it’s really because - psychiatrists and stuff say that’s sexual abuse but I don’t see it that way because it’s something I wanted to do, so it’s hard. So I virtually every day at the [work place]... so I was quite detached from the family in that respect... I wasn’t the only person at the [work place] he was sleeping with either... didn’t bother me as long as I could see him, I was madly in love with him” (Katie)</td>
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</table>
2. "I’m like a square with circles": Feeling different and a disappointment to others

- Experience of growing up in a fearful and rejecting environment leads to a terror of being alone (Katherine)
- Terror of being left alone (Katherine)
- Spending too much time alone made me “crazy” (Charlotte)
- “I’m like a square with circles”: adoptive family are “normal” and “functional” but I like being around the dysfunctional (Jasmine)
- Parents weren’t around much during childhood but dad did try to do fun things with us (Hayley)
- I didn’t have a relationship with parents pre-eleven; au pairs were my parents (Charlotte)
- Parents distanced themselves from me when I was crazy so we lost our relationship (Charlotte)
- I have always found relationships difficult as I don’t understand people or I scrutinise them (Stacey)
- I lived with different people in different cultures growing up (Leyla)
- I still hate being alone now, still. Like there’s a - In my mind it’s like a terror of being alone. But my mum was a bitch. Whenever she found out my dad’s latest girlfriend whatever it was she’d go and dump us girls on the doorstep and leave us there and say wait ‘til he comes out. Pub doorsteps, women’s doorsteps, my nan’s doorstep (Katherine)
- I’d just go to my room. I was in my room a lot, until I went crazy and then they told me I wasn’t allowed a T.V. in my bedroom, because it isolated me so I didn’t really spend a lot of time with my parents, ‘cause I had a TV in my room … Because I used to- I used to come home and just go into my room and watch TV, even when I was from like about the age of nine, when my Nan died really, I had a TV in my room so… (Charlotte)
- “My mum wouldn’t do much with me… She wasn’t that kind of person to sit down and talk and cuddle… We never sat down and ate together (Sienna)
- My mum had got this sort of glorified maid and so all I was doing was just cooking, cleaning, and doing everything for them in the house, for her and their kids, and it was just- it was awful. But err- I was here- with her for about a year, maybe two, and again, I think our relationship was just awful and my aunt who’d gone to Jamaica as well, come back to England for a while to work again and she- I mean I was always close with my aunt, the one who rescued me if you like- I was always close with her. And she could see I was unhappy and she then arranged for me to go and live with another set of relatives, so again I’ve moved. I moved to live with erm- what would be my mum’s cousin but we called them uncle, but erm, so I went to live with him and his family, and again, I’m in this house and there’s this daughter who’s a year or two older than me, and you know when you just don’t fit in and you just feel awful again, and his wife always made me feel- again I always got- you know… less than everybody else, and I’d been treated different because I was- you know, I wasn’t part of the family and I look at it now and think the problem that was happening was that I was just being thrown on people and them not- they weren’t necessarily always happy about having to this so… (Leyla)
| 2. “I’m like a square with circles”: Feeling different and a disappointment to others | I didn’t meet my family’s expectations | • Mother didn’t approve of me because I’m not image-focused and “girly” (Hayley)  
• Mother had stereotypical views of what women should and shouldn’t do (Hayley)  
• I let my family down (Jasmine)  
• I never felt good enough as a child because I didn’t fit in (Leyla)  
• [Family] immediately believed I got an E, my family immedi- “oh God this is not good enough, oh God this is not good enough”... I just minded her in every way- god I was a disappointment and a pain in the arse (Jasmine)  
• I felt distant from [dad] and again I was never... because I suffer from depression and whatever I was never going to live up to what they wanted of me- both of them (Patricia)  
• “I sent her pages of emails, but yeah- her not- you know, cutting my grandparents out of my life, not even getting a choice in it, the make-up, why do I get in trouble if I get a C on a report card in history... not really necessary for engineering which- or veterinary medicine, not really necessary for those. I got a C and my sister gets C’s all the time! You know, no trouble for that so... then I told her all about the- well in November you wouldn’t give me thirty dollars for a sweater I needed but in February a hundred dollars for make-up - no problem!” (Hayley) |
| --- | --- | --- |
| 2. “I’m like a square with circles”: Feeling different and a disappointment to others | Isolation in peer group | • Bullied and an outcast at school (Charlotte)  
• One close friend moved away; anxiety started (Hayley)  
• I was different to peers (Stacey)  
• The bullying got worse... I was in a class of thirty and there were only ten girls in our class so all the girls turned against me apart from one girl who was a bit of an outcast herself anyway so me and her made friends (Charlotte)  
• I switched to a private school- it was like eight thousand dollars a year for tuition? And so the- most of the girls in the class- and the guys- were all about “you have to wear the right clothes from the right shop, make-up” this that and the other, so I didn’t fit in terribly well so I had one friend... then there was another girl who was even more screwed up than me, ‘cause if you did anything to offend her then she wouldn’t speak to you for a week. So I had one really close friend, but then her parents moved her to Los Angeles (Hayley)  
• “[Having friends over] was like this huge trauma that would never happen. So I never had anyone over or anything, so I kind of distanced myself from my friends- what friends I had” (Patricia)  
• I felt really different at school to all the others... I was way ahead... I felt different to all my friends because of the experiences I was having... I felt like at school, I felt that if I answered questions I’d be seen as a no-it-all so I couldn’t really be myself... I didn’t really have friends” (Katie)I found it hard to make friends- I dunno whether- I think I must have isolated myself because I felt different because I knew my friends weren’t going through this (Stacey) |
2. “I’m like a square with circles”: Feeling different and a disappointment to others

- Sister protected by mum from the fearful and rejecting environment so she’s stable (Katherine)
- Parents favour one child and reject others (Katherine)
- Sister favoured by mother because she was girly like her (Hayley)
- Jealous of brother’s relationship with parents (Charlotte)
- Jealous of others relationships (Katherine)
- Good versus bad child (Stacey)

- If I came home with a C on my report card I got in trouble. She would- if she got a C on a report card she was doing well, if she got a B that was REALLY good for her so... my mother saw look [sister’s] wearing nice clothes, she’s figure-skating, she’s wearing make-up and all that... She was doing the girly things (Hayley)
- I was very jealous of him, I’ve always been very jealous- don’t know why. I just- I get like overly jealous... The fact that he saw my parents from a younger age and he- we both went to private secondary school, but he went to private secondary school for two years longer than me ‘cause he went earlier than I did. He went to prep school, so it kind of feels like he gets a better education, that’s why he’s doing so much better now, and he got- he’s got money from people, I’m just jealous of pretty much everything he does (Charlotte)
- “When my brother was born it was quite hard because my mother was so different with him in the sense that- no I think it’s because he’s a boy... he had a lot more attention, she had a lot more understanding... Speaking with my sister, she kind of feels that my mum doesn’t love her... so I don’t know if there’s a connection about girls... even in adulthood he can do all sorts of things to her and she always accepts him back. With me and my sister, it’s like she punishes us... we have grovel (Sienna)

3. My parents didn’t support me growing up but sometimes I found alternative support

- Difficult relationship with youngest sister in childhood but she can be helpful now (Jasmine)
- Don’t feel close to sister (Hayley)
- Brother and I were a team but I broke his trust and confidence in me (Charlotte)

- There was a lot of jealousy because [youngest sister] (incoherent) the family and I used to, you know, I didn’t like that baby. But then I loved her at the same time. We have a good relationship now, but we had a difficult relationship growing up because erm she grew taller than me so I couldn’t bully her anymore and she wanted [middle sister] as well so we used to fight over [middle sister] all the time... I used to say to the angel Gabriel can you take her back? Can you take this baby back, we can’t stand her. (Jasmine)
- I persuaded [brother] I wasn’t gonna try and kill myself again so he persuaded them to let me out and then I went home and tried to kill myself and then he was- kind of ruined all his confidence in me and broke the trust, so and then he kind of started distancing himself (Charlotte)
- We’ve got this love-hate relationship... he’s been in prison four or five times now... It’s really weird, when my brother goes to prison, it’s like he’s a hero, everybody writes him letters and stuff like that... when I go on the ward it’s as if I’ve done something wrong (Katie)
3. **My parents didn’t support me growing up but sometimes I found alternative support**

<table>
<thead>
<tr>
<th>Wider social network to turn to when parents were not available but they were not enough</th>
<th>Surrogate mothers to turn to (Hayley)</th>
<th>I was a difficult child, [sister] was minding me all out through school, all through my teenage years as well ‘cause I was- I used to get very anxious about stuff ‘cause I never liked school- I hated it (Jasmine)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spending a lot of time with extended family (Jasmine)</td>
<td>School was more important to me than home (Charlotte)</td>
<td>I started babysitting her daughter, I didn’t babysit very often because it wasn’t very often they went out but you know I started- I would chat with her a lot- not a lot but a little bit about things… I don’t talk with [friend’s mum] very often, just like less than once a year, but you know I still have her if I need someone to talk to… I don’t open up to her a lot but I know that she’s there if I need her, so yeah, I have these kind of surrogate mothers! (Hayley)</td>
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<td>I felt safe and loved with English couple; I wish I’d stayed with them (Leyla)</td>
<td>When I was sixteen, ‘cause what happened was my school shut down, and so the school I found was kind of like home, I loved my school, it was a small, private school, like all girls, and I knew everyone, even all the new people I knew their names within like a month. So only, there were thirty people in the year… the school shut down cause they lost fund- ‘cause they lost- there wasn’t enough money from people going there erm but then that was like a bereavement, ‘cause it was so, I got so upset and then… I just kind of went crazy after that (Charlotte)</td>
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<td>[English couple] doted on me, I’ve got- and the funny thing is I remember being safe there and being happy with them… I remember looking at the photos and going I was loved ‘cause it almost felt, it felt growing up there was no one, but that was- that would have been the place to- sort of- that I was accepted and loved at that point… Erm, from what I – I mean- from what I can remember, you know, I’d go as far to say it was perfect! There were no problems, uncle [name] he was- as I said he was the kind sort of one that I’d go to and he’d be playful and he take me- do things like take me to his allotment, on a Sunday we’d go to his allotment and then we’d go to the pub and I’d sit in the beer garden and have, you know, a glass of lemonade and everything and we’d head back. So he was the one I did things like that with, and auntie [name] was just this born from routine, knew what was gonna happen, it was tea, a bath and bed and I knew- but everything was just safe there, if that makes sense, it was just all- there was routine (Leyla)</td>
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<tr>
<td>Experience of growing up in a fearful and rejecting environment leads to a terror of being alone (Katherine)</td>
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<td>There was no bond or support with my mum (Leyla)</td>
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<td>Parents did things to show they cared but didn’t seem genuine (Charlotte)</td>
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<td>Appearance is extremely important to me but mum said I was average-looking (Jasmine)</td>
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<td>Mum was frightened of step-father so she couldn’t protect me (Stacey)</td>
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<td>I definitely wasn’t happy, and erm it was hard ‘cause my sister wasn’t really around and you haven’t got mum to do normal things with… I found it really difficult, wanting someone to show me how to use make-up and do my hair and things like that (Katie)</td>
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<td>My mum there was never any kissing or cuddling or anything like that. The only time she ever touched me is when I was really little and having a bath (Katherine)</td>
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<td>Mum said just average-looking and that was to try to- and I can remember that and how that felt… I just felt- at that time I was small, I didn’t know what average was but as a grew older, when I was twelve, my hair was getting darker and darker and I was getting really upset and erm I said “mum, am I pretty?”’. She said “average”. I turned seventeen and I was- I wouldn’t look in the mirror, I started developing acne and I thought I was hideously ugly and to this day I can’t look in a mirror (Jasmine)</td>
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<td>Mum would lock herself in her bedroom doing crossword puzzles most of the time… if my mum caught me pulling out my eyelashes then she’d yell at me erm and nothing was spoken about (Hayley)</td>
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<td>In the playground and I’ve fallen off and I’d split my lip and- and I bled all over my trousers and the au pair had a go at me ‘cause they were really nice trousers, rather than my lip, and then I went home and told my mum and she was like just totally dismissed it, and was just like that’s okay, and like totally ignored it and then another time the au pair was ironing and she accidentally got my elbow with the iron and then I was like- and then I told my mum and she was like, well, totally dismissed it again, she didn’t seem to- whatever I said it was more- whatever the au pair said was more important than what I said like she’d always back the au pair up (Charlotte)</td>
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<td>My auntie said “you wanna get a grip on yourself, shaking like this, you’ll be put in a padded cell”, it used to scare the life out of me, because it wasn’t what I wanted to hear you know, and no one believed me what was going on and no one believed he was hitting me- no one- my brother did and – no one else. My mother knew he hit me but my mother was too afraid of him… (Stacey)</td>
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<td>I never told my mum I was being abused until I took an overdose aged sixteen… [Mum] never believed me, she said that it was- that I was lying and erm she told me that I’d broken up, you know, her relationship, that my brother and sister were gonna get taken away… after that kind of period I tried to close down from what actually happened (Sienna)</td>
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4. I love my children but it is difficult to be a parent to them

Finding motherhood overwhelming at times; wanting to get away from children

- Daughter seeks attention so I need to take a step back sometimes (Jasmine)
- Didn’t want a baby; two weeks of maternity leave was enough (Hayley)
- Can’t relax when son is with me; getting harder as he gets older (Charlotte)
- I can’t avoid spending time with children anymore so being a parent is difficult (Leyla)
- I’d keep busy by spending money to avoid emotions and children (Leyla)

- I got raped and started getting panic attacks, started from there. Not violently raped- he didn’t hit me or anything, but he humiliated me; d’you know what I mean? “Oh ain’t you got skinny tits” and all that sort of thing and it was an absolute shithole the house. But I never reported it ’cause I felt it was my fault (Katherine)
- I got an email on the Monday, don’t want to go back with you, I’ve met someone else, I want to go with her, I met her a couple of years ago and I want to be with her. She’s younger and prettier and more beautiful than you, you’re lost it, you’re past your sell-by date... And it was like all my fears, ’cause I was ten years older than him... I couldn’t stop crying, I was screaming, I was running round the house like a banshee, and [daughter] saying “mummy, mummy, mummy, you’re not- what’s wrong? What’s wrong? Ooh” I said “go, go, go up to [neighbours], I can’t look after you, I can’t look after you [daughter], I can’t look after you” (Jasmine)
- We kept [son] in afterschool club so it would minimise the amount of time that I would be – at that time- on my own with him. Not because I was a danger to him, but because it was my own sanity. I needed all that time to be able to pull myself together so that I could be mummy (Patricia)
- I think it’s a good relationship. Sometimes I say to her you’re too much, it’s not that she’s being too much, it’s just that I find it too much... ’cause you know too much human contact, ’cause kids are demanding and they just need, need, need and I have to take a step back but that doesn’t mean that mummy doesn’t love you, it’s just that mummy finds it a bit (gasps) suffocating sometimes, it’s not that you’re a bad girl, it’s just mummy’s crazy brain, and she knows it’s all mummy’s crazy brain errm... we have a nice thing going, when it’s just me and her- it’s lovely (Jasmine)
- You just can’t do what you wanna do, you can’t just sit down and relax, you have to always be on your guard, or like watching him or thinking when is he due a feed? Do I need to change him? What am I gonna give him for lunch, dinner, breakfast?... When he got to about seven-eight months to like now, it’s a lot harder? ’cause he’s in to everything, he’s mobile, and he screams- he screams a lot, but... and the- and it- it just- it’s harder now he’s older than when he was younger, I thought it would be the other way round, I thought it would be harder when he was younger and easier when he was older (Charlotte)
- If I wanted to run, I couldn’t run because I had her, but I didn’t want to leave her either... I felt very trapped... I don’t know if it’s the feeling of- that it brought up about being a child, I don’t know what it was... sitting with my child brought up feelings about myself and my life and what I’d been through (Sienna)
- I didn’t take to motherhood very well at all... all my mental health problems really started after [son] was born and I just found going from being a busy [job title] to being a stay-at-home mum... I hated every minute of it; I just didn’t take to it naturally. I didn’t bond with [son], I didn’t think he liked me... I was just desperate to get back to work... I’d do more hours so that I didn’t have to go home (Katie)
4. I love my children but it is difficult to be a parent to them

**Despite facing challenges as a parent I love my child**
- Evaluating self as mother; they should have had a kinder mum but I did love them (Katherine)
- Despite difficulties of parenting I love my son (Charlote)
- "Getting the hang of" parenting (Hayley)
- Good relationship with children; we have fun together (Jasmine)
- It was difficult raising a son with ADHD but I loved him (Stacey)
- Relationship with son improved after I understood his ADHD diagnosis (Leyla)

**I remember she said to me- she was coming up to eleven- she said to me “it’s a bit late now init?” and I didn’t do it anymore, I didn’t kiss them good night. And it’s the same like- when I used to wake [youngest son] in the morning- cause he was a sod for getting up for work- I used to rattle the bed, I wouldn’t touch him cause I felt like I was poison. Can you understand that? I felt like he hated me and he would hate me touching him (Katherine)**

**[Daughter] notices it – she says mum when you’re not well you do – she does (sighs) – you do a lot of sighing. And she said you’re crying a lot and you’re staring out the window and it’s hard to get your attention and even though we do play – we play Barbie’s and I get the teddy bears to talk and all this kind of thing, but you don’t really listen to them at all she said, you trail away (Jasmine)**

**It’s nice having someone that like relies on you, that you’re like- I suppose loves you and he’s funny. And I love him (laughs). It’s nice loving someone like unconditionally… like he couldn’t do anything if it wasn’t for me, like he couldn’t eat or anything and so it means that you’re more important to him (Charlotte)**

**[Son] was crying all the time, and I was back and forth with the hospitals and doctors and I just- he’s doing my head in, he’s crying. Oh yeah, when he’s sitting up ,when he’s on the solids, try bathing him, do this, when he’s in nursery, when he’s at school, and they come up with all these scenarios when he’s finally gonna get better, and when he was sixteen he was finally diagnosed with ADHD… I dunno, ‘cause there was no help available, no one wanted to know, a little bit like today. Things haven’t changed. The national health service do not want to know, if it’s a mental health problem they do not want to know (Stacey)**
<table>
<thead>
<tr>
<th>Depression can make it difficult to have a relationship with children (Jasmine)</th>
<th>Periods of depression have made it difficult to have relationship with children (Jasmine)</th>
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<tbody>
<tr>
<td>Trying to manage parenting when experiencing depression and anxiety by distraction but doesn’t always work (Hayley)</td>
<td>I was suffering depression... Just wanted to go to bed all the time, couldn’t be bothered with the children which was sad. I think that’s why they used to go up to the mother-in-law’s quite a bit. I spent quite a bit of time in bed... Didn’t wanna do the housework, didn’t wanna wash, that sort of thing (Katherine)</td>
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<td>Post-natal depression made parenting difficult (Katherine)</td>
<td>When I had him first I was very, very depressed. I had post-natal depression and unfortunately I rejected him... At that time I couldn’t go near him. I thought he was rejecting me, and I was rejecting him. Ah the poor little lad (Jasmine)</td>
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<td>When depressed I don’t feel good enough as a mum so I avoided kids and bought them things instead (Leyla)</td>
<td>If I was feeling a bit depressed and then I have trouble focussing on her. I’m getting a lot better finally but, if I’m having a really depressive episode, if she wants to just sit on the computer playing club penguin all day and I’ll let her and like at the end of the day she’ll remember like “mummy you said we’d do this today” and obviously she forgot but it was my job to remember but you know if I’m depressed I’ll just be like well I hope she doesn’t remember (Hayley)</td>
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<td>I wanted to have that bond, that kind of feeling of love, but then I wanted to put her away... I didn’t want her, I want her, didn’t want her... and she seemed to want me A LOT... I just felt very, very depressed (Sienna)</td>
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4. I love my children but it is difficult to be a parent to them

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<tr>
<th>Reflecting on how mental health difficulties impact on children</th>
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<tr>
<td>• Anxious about my “craziness” affecting son in future (Charlotte)</td>
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<td>• Aware of impact of overdose on daughter but she shouldn’t be in care- it’s having a negative impact of us both (Jasmine)</td>
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<td>• My children didn’t have a nice childhood because of the way I was and my relationships (Stacey)</td>
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<td>• I tell daughter how beautiful she is but I worry about her weight since she’s been in care (Jasmine)</td>
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<td>• Being in prison ruined my image of being perfect mum as daughter resented the parent role she was put in (Leyla)</td>
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<td>• Erm in hindsight if I’d known at eighteen that I’d got borderline I never would have got married and had kids, because… that handicapped them if you see what I mean because I wasn’t the parent I could’ve been or should’ve been (Katherine)</td>
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<td>• The whole thing is just so unjust, she shouldn’t be away from me in the first place, I know I’m not saying what I done is right, I know she shouldn’t have been exposed to me trying to kill myself, I know from a child’s point of view it must have been horrendous, it must have been very, very traumatic, she’s not going to forget this for the rest of her life, it’s going to be burned into her little subconscious, is she going to have issues of erm me, like me, like with erm a (incoherent) of issues but it’s a hell of a lot worse. Is she going to be like me? Oh God, I’m just waiting now for everything to fuck up, ‘cause that’s what I do (Jasmine)</td>
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<td>• September and October last year I was in a really, really bad place. [Son] would never know, possibly I was more grouchy than normal and I probably pulled away from him, so he did know- that’s a lie! (Patricia)</td>
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<td>• Oh my god, I was just in and out of relationships, er... and I just thought—it was just worthless, I was no good; I was no good as a mother.</td>
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<td>• [Daughter] said to [partner] you don’t know what it’s like. That’s all I’ve ever known, listening to my mother threatening to commit suicide and all this. Erm, she’s taken more notice of me, she noticed it… I think it was like a ten, eleven years ago when things started to change, and I started cutting myself, and just losing the plot… I’d been through all these relationships and making my kids move and, my kids had to put up with me living on antidepressants (Stacey)</td>
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<td>• Sometimes when he cries I get a bit angry and upset and I wanna run away, do stuff, and I – I get kind of snap- I get a bit snappy and angry and- but I don’t think it’s affected things so far but- but I think it could if I keep letting myself get really distressed when he’s around. I started having panic attacks again and he’s seen one or two of them and that- I don’t really want him to see them (Charlotte)</td>
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<td>5. Feeling uncertain about parenting skills but where do I get support and feedback from?</td>
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<td>Feeling uncertain about parenting skills but where do I get support and feedback from?</td>
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<td>Well, like my sister [youngest sister] – I wasn’t allowed to visit there anymore when [youngest son] belted his old man. My sister [2nd sister] has told me to get lost these last few weeks. And I just feel rejected anyway by my mum. And it’s terrible ‘cause I haven’t got one family member (Katherine)</td>
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<td>I was rejecting [son], ah the poor little lad… [Middle sister] really came to the rescue. Again. But they’re very good in a crisis, but when the crisis stops, that’s when the criticism starts (Jasmine)</td>
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<td>the teacher did a single file pick up your kids, one parent at a time, so she could talk to you for a couple of minutes if she had anything to say, and she never said anything to me, you know, the rare occasion id drop her off never said anything so after it must have been a few weeks and I said “you never say anything to me- what’s wrong?” (laughs) “Nothing’s wrong – your daughter’s an angel! She gets along with everyone, she nice to everything, she never acts out, I never talk to you ‘cause there’s nothing to say!” (Hayley)</td>
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<td>[Husband’s] been so involved from the start and done everything… even when I was comatose (Patricia)</td>
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<td>I’ve got a family support worker who comes and helps me play, have a behaviour (incoherent) and like how I deal with [son] but more as a family than just me.</td>
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<td>I was having to deal with everything by myself, all the night feeds, I was having to do all by myself and I wasn’t getting any help and I was getting upset about that, ‘cause when I came home [partner] helped a lot- he did the night feeds and I basically slept the whole time (laughs). I need my sleep, ‘cause the- I get – I get really like depressed if I don’t sleep? If I’m tired then I get depressed. (Charlotte)</td>
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<td>I’ve just found it very difficult about the balance of the child and the person, I know there’s no service out there… it’s hard ‘cause I understand that people don’t want children to erm, is the word to suffer? Because the parent has BPD, because a child can be affected by that, so I can’t understand the protecting of the child, but I don’t know, how do you support a child? ‘Cause sometimes I don’t know how to support [daughter] with her journey with me having that kind of outlook ‘cause my thinking is so different… you’re gonna forever be a parent… and I just sometimes feel sad because I’m missing out on [daughter’s] journey… because a lot of chaos (Sienna)</td>
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</table>
5. Feeling uncertain about parenting skills but where do I get support and feedback from?

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<tr>
<th>Making decisions about discipline; turning to others for advice/support but finding it uncomfortable</th>
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<tr>
<td>• Uncertainty about how to discipline my daughter (Hayley)</td>
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<td>• Smacking used as a last resort (Jasmine)</td>
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<td>• I got husband to discipline children but he used smacking and it made me uncomfortable (Leyla)</td>
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<td>• I thought “I’ll teach you a lesson you bitch” and I... phoned the police. And erm, [mum] come home while the police was there. I think it was the first time she ever really walloped me... When [daughter] did come in I was really cross and I hit her- I did hit her- I swung her round by her hair and hit her (Katherine)</td>
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<td>• Yeah I remember being smacked as a kid; I was ALWAYS being smacked... ‘Cause I was always giving the cheek, that’s why... Yeah I think my family will judge me because erm they’re very, very, very, very anti-smacking and sometimes children can be very naughty. Now [Daughter] is a handful at times and sometimes a smack on the hand when she’s stepped over the line (Jasmine)</td>
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<td>• It kind of triggered to me the memory to me that I’d completely forgotten about—should’ve mentioned it earlier- was whenever my sister or I did anything wrong we were sent to the corner and it- and by the time we went to the corner we’re not crying because of what we did wrong we’re crying because mummy hates us and sent us to the corner! So like my daughter, she rarely does anything, so she’s sent to the naughty mat- it’s got to be less than once a month... I’ve decided if she needs to go to the naughty mat we’ll go together and just calm down together (Hayley)</td>
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<td>• When he first came there was this sense of— before we had [youngest daughter]— there was this sense of someone else has come in to help me parent? And so my first things was oh you do the discipline side of things, so push it on to him, which was unfair on him but also unfair on the kids, so he came in and was- what- what was again- its all- I look back now and think why on earth would I have done that? ‘Cause he’s come from [country] with all the traits of the [country] parenting that I hated myself. But he brings it over here so my kids suddenly now have to be seen and not heard which is not what they- you know, they’re not into this, erm, he’s quite into sort of punishment and beating and disciplining but, everything I understand! I can see why he’s doing it, but my kids are kind of like, you know, so that these underlying don’t like mum at this point in time ‘cause what the hell has she done to us and everything, so wasn’t a good time for us either (Leyla)</td>
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<tr>
<th>6. Children don't understand my mental health problems</th>
<th>Children’s understanding of my mental health difficulties</th>
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<tbody>
<tr>
<td>• Children aren’t sympathetic as they don’t understand mental health (Leyla)</td>
<td>• [Youngest son] and [daughter] have both been abusive to me. We’d had a big row at one time and she said “you shouldn’t be allowed to live you old bastard”, and that really, really upset me. Just after [eldest son] died I found one of [youngest son]’s phone numbers in [eldest son]’s book, I rang [youngest son] and I said “can we meet for a coffee?” and he said “fuck off” and I started laughing. I said “ain’t it funny how God takes the best and leaves the shit behind”. I know I shouldn’t have said that to him; he said “yeah that’s why you’re still here you old bastard”. But they hate my guts, they hate with a vengeance (Katherine)</td>
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<td>• Experiencing children as abusive (Katherine)</td>
<td>• I said “ring auntie [name] and” I was just completely – “it’s alright mummy”- she started being the carer “you’ve got the phone here” but [daughter] didn’t know numbers like to dial (laughs)... she made me and herself a jam sandwich...she knows how to use the microwave... she came upstairs and gave me the plate of dinner and she had the plate of dinner and we sat and ate it in the bed (Jasmine)</td>
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<td>• Conflicted feelings for family; loving mother and children but hating them too (Katherine)</td>
<td>• What you do... you switch all your emotions off and you get on with the day... I do that with [son] because there is no way on God’s earth that I want him to know how bad I have been because he’s a kid (Patricia)</td>
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<td>• Daughter’s awareness of my “crazy brain”; she knows I’m not well (Jasmine)</td>
<td>• [Children] have been a bit shitty to me the last few days; I have not found them because my son hasn’t even rung me in four days to see how I’ve been. And if I said to [partner] don’t tell him, he wouldn’t know ‘cause he hasn’t rung to see how I am and it would be nice and I’ve always been there for him for thirty-one years of his life, but you know, he hasn’t got to. It’s not his place so if he feels that he doesn’t wanna ring me then I haven’t rang him. And my daughter yesterday said “it’s all about you” (Stacey)</td>
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<td>• Children don’t show they care when I’m depressed (Stacey)</td>
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7. I find alternative ways of coping when support from services isn't available or helpful

- Seeking support from health services but it varies in helpfulness and availability
  - Support from health services has been varied; DBT wasn't helpful but family support worker is (Charlotte)
  - Practical and emotional support not always accessible when needed (Katherine)
  - Looking for support from health services as I have nothing else (Hayley)
  - Medication usually answer from mental health services rather than regular support (Stacey)

- I was in and out of hospital for about- from about nineteen-eighty to nineteen-eighty-six; in and out, in and out. Just kept going down... I started self-harming in hospital, yeah. But then it went on to home... I remember wondering round like a zombie saying “when am I gonna get better?” “when are the pills gonna work?” Then I started self-harming quite bad... (Katherine)
  - So solution to my problems, give me a bunch of money and I'll be fine (laughs) okay so not the solution to all my problems, but it'll make it- I can cope then! If social services can’t do that, they’re sticking their noses where I don’t need help – they’re insulting me, they’re making me even more paranoid and now I’m kind of getting that - so I’m- I’m very reserved with [support group], because I’m afraid if I say something wrong they’re gonna send me back to social services (Hayley)
  - I’ve had quite a few run-ins with medical people and... I just don’t feel that they’re interested, that they wanna know what’s going on, and its “go home and take your tablets”; that’s not always gonna be the answer, that’s fine yeah, I can’t do it without- I’ve tried, I’ve not taken them and I’ve lived to regret it, but I’d like to think there was more out there for us, whether it was a group (Stacey)
  - Having other, like there’s two other girls in the group, having other people that think and feel exactly the same way gives you some kind of validation I suppose (Katie)
7. I find alternative ways of coping when support from services isn’t available or helpful

- Since having son I’ve had to learn new ways of coping other than self-harming (Charlotte)
- Extreme ways of coping following traumatic experiences (Katherine)
- Extreme ways of coping with relationship difficulties (Jasmine)
- Suicidal wreck by adolescence because of mum’s partner (Stacey)
- I didn’t tell anyone about the possibility of me going to prison as I planned to kill myself (Leyla)
- I’d normally run away to the park, I’d normally leave run away from home shout, scream run away from home, like go to the park, try and kill myself, or go to the woods and try and kill myself, then they’d get the police involved. It’s quite not good stuff... I’m stopping [DBT] at the moment but I didn’t really find it that helpful, I think having [son] helped more than the DBT, ‘cause having him kind of meant I HAD to stop, whereas DBT didn’t- well I had to learn new coping mechanisms but they’re not necessarily DBT coping mechanisms it’s just the fact that I need to learn how to do all the stuff better (Charlotte)
- I used to have white socks and you used to look at them and there’d be blood stains on them, where I’d be scratching where the things were, but yeah- oh it was awful! But I still to this day, do it... I don’t know, at the time- I don’t remember it being- I don’t- I don’t link anything together as to why I was doing it but I was constantly scratching my skin and just being... it was... it was almost I felt like I’d got caught in a trance with doing it, there was no reason for doing it, I remember getting told off for doing it, you know, if someone caught me. (Leyla)
- My friend told her mum... her mum said she didn’t want her to be friends with me anymore... I felt like I’d done something really wrong... so I think I went through a period of feeling very isolated and low... I didn’t know what to do about what she had told me... I never told my mum I was being abused until I took an overdose aged sixteen (Sienna)
Learning to keep feelings inside because it's not okay to talk about emotions

- Learning from parents that talking about emotional things is not okay or safe (Hayley)
- Keeping everything inside; don’t speak to people about feelings (Katherine)
- Mum and dad didn’t understand when I was distressed; restrained or shouted at me (Charlotte)
- Dismissed by mum when I was upset (Charlotte)
- When I told people about mum’s partner no one supported me, I was ignored or called a liar (Stacey)
- Learning not to express emotions runs through each generation in our family (Leyla)

- Interview: I’m wondering when you were upset, who you did- who would you go to? Katherine: I never used to tell anyone, it’s all kept inside...
  Interviewer: What stopped you from telling people if you were upset or anxious? Katherine: I suppose in fear that she’d- I’d be in trouble with my mum. I mean, I never even used to tell my dad that she was horrible to me while he was at work. It just never entered my head to tell- you just didn’t tell.

- Someone must’ve done something when I was little ‘cause I don’t remember ever going to them. It’s like it wasn’t allowed. I remember when I was really little... I remember a couple of things, but one thing was my sister pulled my hair so I couldn’t have been more than four maybe five- my sister pulled my hair really hard and so I cried and my mum yelled at me to go to my room ‘cause I cried and I was like she pulled my hair and she said okay both of you go your rooms (Hayley)

- Being told you can’t be ill, you can’t be upset, crying is always a bad thing... I was always being told I was too sensitive to everything (Patricia)

- It was a very stressful few years. I kind of lost my relationship with them ‘cause I was so crazy... [Mum]’d just kind of ignore it. Or shout at me or pin- hold me down or something. They restrained me quite a lot so that wasn’t fun (laughs) (Charlotte)

- When I was with my grandparents, and I think with my mum as well, the message I used to get was st- everyone used to laugh at me, I remember being laughed at and told I thought I had more tears than everybody else and I was always crying... there’s a lot of sadness there but I was always told don’t show your tears, don’t cry, you’re annoying- it was almost an annoyance to everybody if I cried or anything, so there was never any comfort it was just being told you were just stupid or silly (Leyla)

- “My dad was brilliant, he was really good... my sister used to pick us up form school... emotionally he’s not really- he hasn’t- he’s not really there emotionally, he made sure we had everything we needed... there was no affection or anything like that... he seemed to be permanently stressed, so there was not much love and affection I suppose” (Katie)

- I allow her go through the emotions anyway... that’s how she feels... whereas my mum used to tell me, stop the crying ‘you cry too much’, so in my head crying is negative... I try to let her cry (Sienna)
8. I was taught to keep feelings inside but it leads to outbursts and violence

- Trouble managing emotions as they haven’t matured (Jasmine)
- Dad and I both have outbursts (Charlotte)
- Not feeling in control of self and anger (Stacey)
- Parenting is difficult because I can’t understand or predict my mood and my reaction to children (Leyla)
- It was me saying to CAMHS I’ve hit her because my anger and hey can you guys look at this for me, and all that happened is I got cautioned... [Daughter] is kind of- kind of feisty so she’s another [son] - she’s very argumentative and why should I do this? And why- duh duh duh? And I think I described it as she’s playing Russian roulette with me, sometimes, because I don’t know what my mood is gonna be like. I mean, she can do it on one day and I can manage to... walk away from it and think “okay” on another day I just wanna kill her! (Leyla)
- I was still in bed, and I’m not a violent person but if I’m- if those buttons are pressed I will go into one and I ended up punching him in the nose and I broke his nose... [he said] “I can see you- your family, they don’t love you- you’re just a burden to them and they’re probably ashamed of you, that’s why you’re in England on your own”... But I reacted. I didn’t say could you stop now ‘cause if you don’t stop you’re gonna be sorry, I’m feeling very angry. It was just back again to the nursing situation because that woman that was bullying me (Jasmine)
- I had a lot of anxiety about money, a lot of anxiety, so I was getting really short-tempered and what that did, I was short-tempered and then if I snapped at her, then I automatically saw myself when I was little and my mother snapping at me and that made me even worse, oh wait, I’m becoming her (Hayley)
- [Dad] gets angry very easily which like me, kind of just has outbursts... I get a bit angry and upset and I wanna run away, do stuff, and I – I get kind of snap- I get a bit snappy and angry (Charlotte)
- [Son] had lost all contact with his father ‘cause he got remarried and his new wife didn’t want him haven’t contact with [son] which is fine... she was giving me all this on the phone, I said, d’you know I said if you said that to my face I’d come down there- if you said that to my face I’d slap you. She went “you know where I live” so I went down there and I hit her (laughs) (Stacey)
- “She used to come up and she’d squeeze me (holds wrist), she’d pinch my skin, and she’d say “that painful enough?” and I’d say ‘why you doing that for?’ she’d say ‘because that’s what I feel when you [self-harm], she said you wouldn’t believe the pain you put me through” (Stacey)
- If I could have one thing I’d like to have consistency, I’d like to be level with him... sometimes if he does something wrong I can laugh about it, and other times I can lose the plot... I can be really nasty verbally (Katie)
9. Sometimes my children end up in similar situations to what I experienced but I try to do things differently to my parents

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<th>Trying to do the opposite to parents because I don’t want children to experience what I have; corrective scripts</th>
<th>• I don’t want to see daughter end up like me (Jasmine)</th>
<th>• I try and encourage her to talk about things ‘cause I think the last child-minder was telling her “you have to be brave when you’re sad” and so you know sometimes when I find her crying and she’s trying to you know trying compose herself or something you know I have to tell her you know look [daughter] it’s just you and me you can be sad. If you’re in school maybe, but you’re too little to understand the difference, it’s tough right now- if you wanna be sad, you be sad... ‘cause I was never allowed- If I was upset about something I had to go to my room, we would never talk about it (Hayley)</th>
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<td></td>
<td>• Explaining to daughter what she’s doing wrong; mum never explained (Jasmine)</td>
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<td>• Good parent is opposite to mother so that’s what I try to do (Hayley)</td>
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<td>• I can’t think of anything I’d do that’s similar to my parents; they dismissed me and I didn’t know if they loved me (Charlotte)</td>
<td>• I think when I was younger my mum wanted to avoid it at all costs because of perceived stigma, et cetera, whereas if [son] shows any signs of it- and I have said when he’s older, when he’s a teenager – I’m not gonna be smothering him, but I am going to speak about things with him. I want him to feel as though- even if he can’t talk to me directly... I want him to feel like he can talk to others (PATRICIA)</td>
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<td>• I can’t think of anything I’d do that’s similar to my parents (laughs)...Hopefully he’ll realise that I love him rather than not realise... Like I don’t know if my parents loved me but hopefully like he’ll realise I love him, he’ll kind of know, I don’t knowl... I never really saw them really. I didn’t really know them and they never said it that much... They never really said they were proud of me; it was mainly negative (laughs) (Charlotte)</td>
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<td>• I can be maybe quite firm like her but in a different way. Don’t think there is anything much... because I’m so fearful of being like my mum I wanna be the extreme opposite so [daughters] got millions of toys ‘cause I just don’t wanna be like her (Sienna)</td>
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<td>• I think I’m a lot more touchy-feely... he can talk to me about anything and he does... things I never would have dared asked my dad... I couldn’t imagine lying on the sofa with my dad and having a hug and my mum was always sat in the chair drinking... (Katie)</td>
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</table>
| Mimicking parent’s experiences across generations; replicative scripts | - Children have gone on to have their own mental health difficulties that are managed with substances (Katherine)  
- Daughter looks after me like we looked after our mum; it builds compassion (Jasmine)  
- Mum and I both brought shame on our families by getting pregnant at sixteen (Leyla)  
- I find others to give the love to kids that I can’t like my mum did (Leyla)  
- Son uses alcohol to manage emotions (Stacey)  
- Katherine: ...I used to help them read and help them with their homework and that but I erm... I wasn’t- I don’t feel like I was a good mum. Well the kids have got everything today; they don’t need mums half the time. I can’t– I can’t remember interacting with them constantly but erm I did love them. I did love them. Well... as far as I know I did.  
Interviewer: Do you think they knew that?  
Katherine: Probably not.  
- The quick to anger is similar to my mum, like the lack of patience... stupid things like sitting down with [son], playing a game with [son], oh I have to go and do the washing and ironing.... With mum it always felt like keeping the house clean was more important than playing a game or she was always in the kitchen, she would never sit in the lounge... lunch or dinner, and sometimes I can be like that (Patricia)  
- [Son is] sadly an alcoholic, erm... that just adds more fuel to the fire because I worry about him- I worry about him terribly... When he was starting his detox which failed miserably I was convinced he was gonna die ‘cause they were saying you know you can die doing a detox if it’s not done properly through alcoholics anonymous (Stacey)  
- It was funny ‘cause she got put into a situation which absolutely mirrored how I grew up because literally next door my neighbours who’s since passed on she-erm, she looked after her, she was an, you know, an older white lady and she- she looked after [son] and [daughter] as well initially and... she’d been really strict with them, she’d been kind of- she was younger I suppose and it was like, you know, she- so she’d always had them, so since we’ve moved here she’s been here and she was almost like their sort of gran to them, d’you know what I mean? Erm, although [daughter] and [son] knew her-e she was [next door neighbour] to [daughter] and [son], but when [youngest daughter] came along she was Nan to her and so again she made it easy too, because she, you know, she lived next door. [Youngest daughter] used to get up on the weekends and you know, put on her clothes “oh mum I’m going over to nanny’s” and she’d be over there for the weekend, I’d probably get her back in the evening and Sunday she’d go back over her again, so a lot of her time was spent next door, which was really like... I did see the irony after a while; I was like this is so mad! (Leyla) |
| 9. Sometimes my children are exposed to traumatic experiences differently to my parents | **Children**
- I went to prison for stealing from work when professionals gave me false sense of hope that I couldn't leave the house... social services convinced her to put me and [youngest son] up - 'cause it was only a baby, I think he was a year old- and she said the two older ones will know they'll be home in a couple of weeks and so we got the house back. But [eldest son] got sexually abused while he was in care, but I never found out until after he died- his girlfriend told me. He never ever told me (Katherine)
- After I'd had [son] and he punched me in the eye, this one (points to left eye) and I sort of lost part of my sight for a while... I think because she's seen so many men and so many arguments... I feel pretty bad because we were moving a lot of the time, I was with a new bloke or a new husband, erm... and I look back and I feel guilty cause it couldn't have been easy for [children] (Stacey)
- [Daughter] became really resentful towards me, because obviously this had happened, erm, what she then had to do- she was- she was eighteen as I said- and she was at college, and life was good for her as far as she was concerned, she didn't have any worries at all before. Suddenly she comes back, mums in prison and she has to run around with my sister and organise things like taking over tenancy, 'cause this is a council housing association property, so she had to take over the tenancy, claim housing benefit and claim for her and her sister sort of thing (Leyla)
| **Replicative script**
- Son and daughter have both been exposed to traumatic events in family (Jasmine)
- Took overdose in front of daughter; she went into care (Jasmine)
- Abused by husbands physically and verbally (Katherine)
- Husband used to hit me, then I had short-term relationships (Stacey) |
APPENDIX O.

Findings from the staff focus group.
Following the data analysis a focus group was held with staff members who worked at the SUN project, facilitating peer support groups for people with difficulties associated with a diagnosis of personality disorder. Attendants at the meeting included the researcher, the service manager, the clinical lead for personality disorders in the Trust, and five group facilitators.

In keeping with the hypothesis that mothers found it difficult to move on from their childhood experiences, the team commented that the experience of being mothered was central in the clients’ minds. While they tried to parent differently to their own parents, they were not equipped to do so and were very upset at the realisation that they had replicated their own experiences.

They identified that the themes seemed to capture the feelings they witnessed when working with mothers diagnosed with BPD that focused on self-blame and guilt. They felt that they were not there enough for their children, and felt guilty about the impact of their own difficulties on their abilities to parent.

Staff raised a gap in the research that the researcher has also reflected on; there was an under-representation of mothers whose children who have been taken into care. From running groups with individuals diagnosed with BPD, staff recognised there was a high occurrence of this, yet only one participant, Jasmine, had had this experience. This was recognised by the researcher as a potential volunteer bias; individuals who had children in care might have found the interview too painful. To staff this was an important part of exploring motherhood in this client group, as the mothers they encountered often struggled to recognise their role in the children being taken into care. In relation to this issue they identified a common theme in clinical practice whereby mothers would “replace” a child put into care by having another baby.
They identified that they often heard of parentification when mothers they worked with had adult children; when their children became adults the mothers expect the children to look after them. This fits with the theme around children not understanding the mother's mental health difficulties. The disappointment and frustration associated with this only occurred when mothers had adult children, indicating that there is an expectation put upon children once they become adults.

Staff had also noticed mothers were aware of the intergenerational pattern of mental health difficulties. They spoke of mothers recognising that some of their children have gone on to have similar difficulties. If the child had mental health difficulties mothers referred to them as being like themselves, whereas if a child grew up with little or no mental health difficulties, then they were referred to as “taking after” the father. This belief further reinforces the self-blame and guilt the mothers experience.

When considering the age range of the mothers interviewed (as one of the limitations), staff commented that they noticed older mothers diagnosed with BPD offering hope to younger mothers, that children can be more difficult to parent during the teenage years but that parenting and life gets better. Interestingly, this hope did not emerge for the mothers of adult children in the research, who were perhaps more hopeless than the younger mothers.

Staff also described an element of avoidance of looking at the relationship with their own mothers in the mothers they worked with. While the mothers were aware it was a difficulty, they were fearful of what arise if they spoke about it.

With regards to seeking help, staff had noticed that the mothers they worked with frequently access self-help groups (run by service users) for mothers or young parents. They also felt they were willing to seek help from professionals, but were
reluctant to ask for help from family. An issue staff noted in group settings with mothers diagnosed with BPD is the issue of collusion. Group members may collude with mothers that they are a "good mother". Staff members wondered if it was more bearable to be in a group with someone who is "good" and not at fault. Being in a group with a "bad mother" may feel intolerable.

When speaking specifically about social services, staff had witnessed mothers being very defensive and wary of what they say that might relate to their children being taken into care, similar to the views of mothers interviewed in the research. They described mothers feeling powerless when social services were involved; therefore they become fearful of their involvement.

Finally, staff raised a key societal issue that motherhood is portrayed as "easy". Anyone who struggles with this role is denigrated in society, thus reinforcing the guilt and self-blame they already experience.

While there were a number of overlaps with what staff had noticed from working with this client group to what was found in the research, there were some themes that failed to emerge in the data that might relate to the volunteer bias. There was an under-representation of mothers with children in care compared to those encountered in clinical practice. Furthermore, there was an under-representation of older mothers who felt parenting did become easier as the children grew older. Again, this might be linked to the volunteer bias, with mothers who are struggling with their role seeking a space to share their story.
APPENDIX P.
Reflective diary excerpts.
I have completed my first interview.

I was most struck by the fear of rejection/abandonment across generations by both her parents and her own children. I also noticed that emotion came across as something to be hidden, as it may lead to further rejection if expressed.

There did appear to be inter-generational transmission of BPD traits, although their expression varied. The "cold mother" idea came to light as more important than another positive person who was largely absent.

I felt sad that her fears of abandonment/rejection were true; the only positive relationship she maintained with her child resulted in suicide.

I was surprised by the forensic element to the story, and how impulsivity often resulted in harm to self, or others (intended or not). I also felt enraged at mental health services for letting events continue.

Person with BPDj although I need to bear in mind that her difficulties began when it was less recognised and acceptable as a diagnosis and there were some positive things and services.
I had my second interview, which was very different to my first.

It was difficult to keep the interview on topic as it kept seeming to veer off topic. I was discussing a few areas of interest, e.g. hobbies, but I felt that this information did not necessarily address the area I was looking for.

This interview was also very different in terms of the home environment. There was a "happy" childhood, as she described - this did not fit with the anxiety and self-harm she described.

There seemed to be a lot of guilt about expressing negative feelings towards parents - might be linked to being adopted?

Expectation of gratitude?

There seemed to be less reflection in her narrative: acknowledging how OD in spite of her child, but then saying she shouldn't be in care; defence of protecting self?

Despite Jasmine's story being less "sad" than Katherine's I still felt very sad when listening to her story - a lot of guilt related to her family? Sense of not fitting in with family - enough to result in further regulatory difficulties?