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Literature Review

Empirical Research Project

Reflective Commentary

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Nikolaos Tzikas

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DECLARATION

I declare that the material submitted for examination is my own work. The ideas and findings of others have been referenced in accordance with the guidelines provided, and any work by others has been acknowledged.

I understand that anti-plagiarism software may be used to check for appropriate use of referencing.

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Impact Statement

This study adds to the body of literature exploring parents' experiences with Borderline Personality Disorder. The literature review highlighted the many challenges those parents face in their everyday lives and how they manage the complexities of their parenting role in a society that can be stigmatised and marginalised. Understanding deeply their experiences can support and offer new ways of working clinically with such a population.

The findings of the empirical study offer an insight into the role of their diagnosis in their parenting styles and are understood via their accounts of early trauma and adversity. This study highlights the importance of a trauma-informed approach when working with such parents to address their complex emotional experiences within the context of being on the edge of care and the anxiety that at the end of the involvement with such service, they will either lose or continue to have custody of their child. Although, a highly anxious and challenging time for those parents, the majority of parents were also able to reflect and give detailed accounts of moments of enjoyment with their children, engaging and bonding through play and activities. The understanding gained from this study can inform clinical practice in relation to providing the most useful and appropriate interventions for parents whose children are under the age of 3 and on the edge of care. Our findings emphasise the importance of trauma-informed services and clinicians working with such a population as well as providing a space where parents can think in depth about their emotional experiences and integrate their views on parenting that is both challenging and rewarding. Due to the young age of their children, this study shows particularly the importance of parents giving a perspective that their children have bodily and psychological needs.

Policies should acknowledge the importance of resourcing clinical services that can provide an empathetic and more holistic approach to such parents. This study can also be an important contribution to the Child and Adolescent Psychotherapy (CAP) field as some CAP professionals engage with children who have lived with parents who have similar experiences or with young adults who have a diagnosis of Borderline Personality Disorder.

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Part 1: Literature Review

Title:

Experiences of Parenting among Parents with a Diagnosis of Borderline Personality Disorder: A Narrative Literature Review

Word Count: 7850

Abstract

This paper will examine and review the literature on parenting experiences among parents diagnosed with Borderline Personality Disorder (BPD). This review aims to understand the complexity of such a diagnosis and its aetiology and delve deep into the parenting experiences of parents with BPD diagnosis. A systematic search took place, looking into titles and abstracts in the electronic databases Web of Science, MEDLINE, PsychINFO and ScienceDirect and identifying quantitative and qualitative research articles. Aetiological models strongly suggest a combination of environmental and genetic factors in the development of BPD. The main findings indicate that parents with BPD diagnosis have experienced early adversity and trauma and lack positive internal parental models, which puts them in a difficult position at the start of their life as parents. Due to the lack of understanding of such diagnoses from professionals, parents often feel misunderstood and isolated. Parents with BPD diagnosis have often described feeling overprotective towards their children, experiencing difficulties setting boundaries, and having negative intrusive thoughts that something terrible will happen to them. There are feelings of ambivalence, but they also enjoy playful interactions and positive experiences with their children. This research highlights the impact of early adversity and trauma on mothers' parenting experiences. Further research needs to understand more in-depth parenting experiences of parents diagnosed with BPD. Services need to consider how best they can support this population in a trauma-informed way, as the risk of child removal may exacerbate parents' anxieties and distress.

Keywords: Borderline personality disorder, trauma, parenting experiences

Experiences of Parenting among Parents with a Diagnosis of Borderline Personality Disorder: A Narrative Literature Review

Introduction

This paper will examine and review the literature on parenting experiences among parents diagnosed with Borderline Personality Disorder (BPD). This diagnosis is controversial; however, it has been read and studied, and some common emotions and experiences have been identified. I will go on further to understand and answer some questions about the already complex history of these parents and the relation to their current parenting experiences. It will look into attachment styles and research considering their mentalizing capacity. In addition, I will look at the effect of those parenting experiences on their children's development and how they experience their children.

First, I will describe some of the characteristics of a BPD diagnosis. Then, I will explain further and explore some aetiological models supporting different ideas regarding the aetiological explanation of BPD. Are they environmental or biological factors, or both? The family, twin and cross-cultural studies will be explored in light of the nature vs nurture debate. The review's primary focus will be the parenting experiences of parents with BPD. This will help to understand how individuals with BPD traits can affect parenthood. At the end of the review, there will be a discussion of the parenting experiences, conclusions and a reference to the gap in the literature.

Methodology:

A systematic search was conducted across electronic databases, including Web of Science, MEDLINE, PsychINFO, ScienceDirect, Psychoanalytic Electronic Publishing (PEP), EBSCO, Wiley Online Library and OvidSP online platforms. The search targeted titles and abstracts of articles about parenting experiences among individuals diagnosed with Borderline Personality Disorder (BPD). The search concentrated on identifying prevalent research and relevant journals published between 1980 and August 2020. The selection of 1980 as the starting point was motivated by the significant emergence of BPD in the Diagnostic and Statistical Manual of Mental Disorders (DSM) during that period, marking a pivotal juncture for scholarly interest and expansion in the literature. The following terms and variations were used: ‘borderline personality’, ‘parenting’, ‘experiences’, ‘rewards and challenges’, ‘parents’, ‘community’, ‘interventions’, ‘parenting experiences of borderline personality disorder’. Additionally, the search encompassed synonymous terms such as "Emotionally Unstable Personality Disorder" (EUPD), serving as an alternative descriptor for BPD.

Inclusion criteria comprised quantitative and qualitative studies concerning adults diagnosed with BPD globally and psychology or psychoanalytic papers focusing on BPD. Specifically, the review encompassed research examining the parenting experiences of individuals with a BPD diagnosis and studies exploring attachment and mentalizing capacity within the context of BPD.

Furthermore, articles investigating the influence of parents diagnosed with BPD on children's development were meticulously examined, mainly focusing on parental attitudes towards and experiences with their children. However, studies exclusively centred on the children's perspectives were excluded from the evaluation, aligning with the primary objective of this review to explore the parenting experiences of individuals diagnosed with BPD.

Aetiology of Borderline Personality Disorder – Nurture vs Nature or a mixture of both?

Borderline Personality Disorder (BPD) is a highly contentious diagnosis within the field of mental health. It is often depicted as a multifaceted mental health issue characterised by challenges in behaviour and emotion processing, unstable interpersonal relationships, mood volatility, and self-defeating tendencies that hinder social functioning. Additionally, individuals with BPD may exhibit extremes of idealisation and devaluation towards others (American Psychiatric Association/APA, 2013). Conversely, some researchers argue that BPD is a consequence of complex trauma (Kulkarni, 2017). Regardless of the perspective, those diagnosed with a personality disorder often face obstacles in accessing and receiving adequate mental health support (Steele et al., 2019). Furthermore, the diagnostic label has been scrutinised for its highly stigmatising nature (Newton-Howes et al., 2006). Research indicates that clinicians may harbour judgmental attitudes towards individuals with a personality disorder diagnosis, thereby hindering their ability to access help (Markham & Trower, 2010). The controversies surrounding BPD extend to challenges in accurately assessing and diagnosing such intricate conditions.

Studies by Fonagy and Luyten (2009) have revealed elevated rates of psychiatric comorbidity among individuals diagnosed with BPD, with a notable predominance of female patients (Skodol & Bender, 2003). This gender disparity raises concerns about the potential for gender biases among clinicians and researchers in diagnosing BPD. Societal norms often dictate that women should express anger in a subdued manner, contrasting with the expectation of men to exhibit assertiveness. Consequently, women expressing legitimate emotions such as rage and anger may be perceived as deviating from societal expectations, possibly contributing to the overdiagnosis of BPD in women. However, research indicates minimal gender-based differences in clinical presentations and functioning among individuals with BPD (Busch et al., 2016; Johnson et al., 2003). Thus, the tendency to pathologise women's emotional expressions may reflect societal biases rather than inherent gender differences in BPD symptomatology.

These complexities underscore the importance of developing a nuanced understanding of individuals exhibiting traits associated with BPD. Rather than hastily applying diagnostic labels, it is crucial to delve into the intricacies of their experiences. By doing so, clinicians and researchers can avoid oversimplification and better comprehend the diverse manifestations of psychological distress.

Understanding the diagnosis of Borderline Personality Disorder (BPD) is imperative due to its significant prevalence in the population. Research suggests that BPD affects approximately 1.6% of the global population, with indications that the actual prevalence may be even higher (Tyrer et al., 2010). Studies conducted in various countries, such as the Netherlands and the United States, consistently report substantial percentages of the population exhibiting symptoms indicative of BPD (ten Have et al., 2016; Lenzenweger, 2010). In Australia, mental health services report alarmingly high rates of BPD among both outpatients and inpatients, highlighting the urgent need for a deeper understanding of this complex disorder (National Health and Medical Research Council/NHMRC, 2012). These statistics underscore the global impact of BPD and emphasise the necessity of prioritising research efforts to comprehend its underlying causes.

Various theories propose explanations for the development of Borderline Personality Disorder (BPD), with debates revolving around whether it primarily stems from environmental influences or results from an intricate interplay between environmental and genetic factors. While the exact aetiology remains unclear, contemporary models acknowledge the multifaceted nature of BPD, recognising interactions between genetic, neural, behavioural, family, and social factors (Winsper, 2018).

One prominent model is Linehan’s biosocial theory, which posits BPD as a disorder arising from maladaptive interactions between biological vulnerabilities and invalidating environments (Linehan, 1993). Linehan suggests that individuals with BPD experience dysregulation across all facets of emotional responding due to a combination of biological factors, such as limbic dysfunction and invalidating caregiving environments. Conversely, Fonagy et al. (2017) present a socially-oriented model of BPD, highlighting risk factors during the early years of a child’s life and their relationship with primary caregivers. They argue that the absence of non-verbal cues, such as eye contact or turn-taking, can hinder the development of social knowledge and the capacity to relate to others, ultimately contributing to difficulties in mentalization— the ability to comprehend and interpret emotions. Therefore, the infant develops psychological defences of being constantly vigilant or closed off to communication, leading to difficulties relating to others.

Both Linehan's and Fonagy's models underscore the crucial role of the caregiver-infant relationship in shaping emotional development during infancy. According to Fonagy et al.’s model, challenges in mentalization contribute significantly to difficulty relating to others, a hallmark trait of BPD.

In conclusion, comprehending the diagnosis of Borderline Personality Disorder (BPD) requires consideration of its complex aetiology, which involves interactions between genetic predispositions, neural mechanisms, environmental influences, and early caregiving experiences. By understanding these factors, clinicians and researchers can develop more effective interventions and support systems for individuals affected by BPD.

The theories above suggest that children who experience a lack of understanding and validation of their emotional states from primary caregivers may develop deficits in emotional regulation that persist into adulthood, contributing to the manifestation of Borderline Personality Disorder (BPD). Additionally, Hughes et al. (2012) emphasise the role of frontolimbic dysfunction in BPD, proposing that successful co-regulation during infancy through secure attachment relationships lays the groundwork for later emotional regulation and strengthens neural structures related to self-control. They argue that children with poor self-control and insecure attachment styles are more prone to emotional dysregulation, which may be associated with deficits in prefrontal cortex resources crucial for affect regulation. Supporting this, Schmahl et al. (2003) and Donegan et al. (2003) found increased activity in brain regions such as the dorsolateral prefrontal cortex and the amygdala among individuals with BPD when exposed to emotionally aversive stimuli, suggesting abnormalities in neural processing related to emotional stimulation.

The aforementioned theoretical models offer a comprehensive understanding of the aetiology of BPD, emphasising the intricate interplay between genetic predispositions, environmental factors, and neural mechanisms. However, family and twin studies can provide additional evidence further to elucidate the nature versus nurture debate in BPD aetiology. For instance, Gunderson et al. (2011) conducted a family study suggesting a genetic component in the development of BPD, with first-degree relatives exhibiting a higher risk of developing BPD traits compared to relatives of non-affected individuals. However, the study is subject to methodological biases, such as selection bias, and fails to account for potential sex differences in BPD prevalence. Moreover, the study overlooks the influence of shared environments among first-degree relatives, which may confound genetic findings.

Twin studies have played a crucial role in investigating the genetic underpinnings of Borderline Personality Disorder (BPD). Seven studies have successfully narrowed down the previously wide-ranging estimates of heritability, which now fall within the range of 32% to 72% (Reichborn-Kjennerud et al., 2015). However, it's important to note that these studies were not conducted with random participant selection and focused solely on sub-thresholds of BPD traits. Consequently, the relatively small sample sizes raise concerns regarding the precise heritability of BPD.

To address these concerns, Skoglund et al. (2021) conducted an extensive study involving a large cohort of 1,851,755 individuals in Sweden, among whom 11,665 received a formal diagnosis of BPD. Their analysis revealed a heritability estimate of 46%, indicating a significant genetic contribution to the disorder. The remaining variance was attributed to unique environmental factors specific to each individual.

While these findings provide valuable insights into the genetic basis of BPD, it's essential to interpret them within the context of their methodological limitations. Future research with larger, more diverse samples and randomised participant selection methods would further enhance our understanding of the genetic and environmental factors contributing to BPD. Additionally, studies examining the interactions between genetic predispositions and environmental influences are warranted to elucidate BPD's complex aetiology comprehensively.

With a significant portion of the variance in BPD attributed to unique environmental factors, it becomes apparent that individuals with BPD traits are heavily influenced by their life experiences, which are often shaped by cultural contexts.

BPD manifests across various cultures and is frequently associated with social disadvantage and deprivation (Loranger et al., 1994). Studies conducted in different cultural settings shed light on the prevalence and correlates of BPD within specific contexts. For example, Huang et al. (2012) examined 400 Chinese participants and found associations between BPD diagnosis and experiences of childhood abuse, echoing similar findings by Wang et al. (2012) in a study involving 1402 Chinese participants. However, cultural differences become apparent, as the fear of abandonment—one of the main criteria for BPD—may not be as applicable in collectivistic cultures like China.

Similarly, meta-analyses conducted in India did not report significant prevalence of BPD traits (Reddy & Chandrasekhar, 1998). Additionally, studies comparing ethnic groups within Western countries revealed variations in the incidence of personality disorders, with lower rates observed among African-Caribbean patients in London (Tyrer et al., 1994) and immigrant populations in Geneva (Baleydier et al., 2003) compared to indigenous populations. These cultural differences in the prevalence and presentation of BPD suggest that environmental factors and broader cultural contexts play pivotal roles in shaping the development of BPD in individuals.

It is plausible that behaviors and personality traits are conceptualized and assessed differently across cultures, leading to variations in the recognition and interpretation of BPD symptoms. What might be considered clinically significant in Western cultures could be normalized or culturally accepted in other contexts. Furthermore, the influence of culture on family dynamics and social structures may impact the manifestation and interpretation of BPD symptoms. In Western cultures where extended families are less prominent, BPD symptoms may be more prevalent compared to Asian cultures, where familial support systems are more robust and integral to cultural values.

In essence, the psychological development of personality disorders, including BPD, is inherently intertwined with cultural phenomena. Understanding these cultural nuances is essential for accurately assessing and addressing BPD across diverse populations, highlighting the importance of culturally sensitive approaches in research and clinical practice.

Ibrahim, Cosgrave, and Woolgar (2018) conducted a comprehensive study on childhood maltreatment and its association with Borderline Personality Disorder (BPD), drawing from ten longitudinal studies. Their analysis concluded that maltreatment acts as a significant risk factor for BPD, with the severity of abuse amplifying this risk. Similarly, Stepp, Lazarus, and Byrd (2016) conducted a systematic review, identifying family and maltreatment risks as key factors linked to BPD. Johnson et al. (2002) reported that individuals subjected to physical, sexual, and emotional abuse are at higher risk of developing BPD. Furthermore, Zanarini et al. (2000) found that a striking 84% of individuals diagnosed with BPD had experienced emotional abuse and neglect during childhood. Bateman and Fonagy (2008) emphasized disrupted attachment or affiliative systems as influencing the development of impaired social cognition, a hallmark feature of BPD. Numerous studies have underscored early attachment insecurity as a critical factor in BPD development, positing that it may also impair the capacity for mentalizing (Fonagy et al., 2003; Lyons-Ruth et al., 2005). Therefore, the quality of the caregiver-infant relationship emerges as a significant determinant in the development of BPD traits later in life.

Individuals diagnosed with BPD often report experiences of neglect and abuse in early relationships, which undermine their social cognitive capabilities. These adverse experiences may induce changes in neural mechanisms associated with emotional dysregulation and structurally impact the developing brain. The recurrence of such negative experiences during childhood can profoundly affect emotional and physical development, underscoring the importance of considering the interplay between environmental influences and genetic predispositions in BPD etiology.

In conclusion, the cultural variations and controversies surrounding the diagnosis of BPD can be attributed to the dynamic interaction between environmental, psychological, and genetic factors. Multiple studies have established a strong association between BPD traits and early-life experiences of neglect, emotional, physical, and sexual abuse. Consequently, individuals diagnosed with BPD often carry the burden of traumatic relationships characterized by abuse and neglect into adulthood, potentially impacting their own parenting experiences. Understanding the diagnosis of BPD through the lens of parenting experiences is particularly pertinent, given the societal expectations imposed on mothers and their pivotal role as primary caregivers. By delving into the etiology of BPD, we can gain valuable insights into individuals navigating this diagnosis, comprehend its implications for their parenting styles, and appreciate its profound impact as they transition into parenthood.

Rationale:

The rationale for investigating the experiences of parents diagnosed with Borderline Personality Disorder (BPD) stems from research indicating potential negative outcomes for their children, likely attributed to compromised parenting abilities. Eyden et al. (2016) conducted a review revealing that BPD symptoms correlate with insensitive, overprotective, and hostile parenting behaviors compared to mothers without BPD or BPD symptoms. Similarly, Petfield et al. found that mothers with BPD require increased assistance with parenting and have a heightened risk of displaying insensitive behaviors.

Observation-based studies by Crandell et al. (2003) and Hobson et al. (2009) further corroborate these findings, demonstrating that mothers with BPD exhibit insensitivity, intrusiveness, dysregulated affective communication, and intrusive behaviors towards their children. Additionally, Macfie & Swan (2009) observed a role reversal in the mother-child relationship, with mothers discouraging their children from developing autonomy due to fear of abandonment.

As children typically assert their autonomy during the toddler period, mothers with BPD may exhibit fear of separation, hindering their children's autonomy and promoting proximity-seeking behavior instead. These insights shed light on the challenges faced by mothers with BPD, characterizing them as potentially hindering their child's development.

Quantitative studies align with these observations, showing that mothers with BPD display more intrusive behaviors, lack mentalizing capacity towards their children, and exhibit invalidating and punitive tendencies. However, limited exploration exists regarding the experiences of parents with BPD themselves.

Understanding the unique challenges and perspectives of parents with BPD is crucial, as they often face high involvement with social services and encounter difficulties in accessing support. Therefore, shifting attention towards investigating parents' experiences with BPD can provide valuable insights into their needs and inform the development of appropriate interventions aimed at supporting both parents and their children.

Parenting experiences of parents with BPD diagnosis

Children of parents diagnosed with Borderline Personality Disorder (BPD) often encounter significant challenges, potentially leading to adverse outcomes and increased involvement with social services, including instances of child removal. However, despite these difficulties, there remains a paucity of research examining the parenting experiences of individuals diagnosed with BPD. Exploring this aspect could offer valuable insights into their unique needs and perspectives, thereby facilitating the development of more effective support strategies. Given the ongoing controversy surrounding this diagnosis, it is imperative to ensure that the voices of parents with BPD are recognized and heard, particularly regarding their parenting, which is often perceived as problematic.

Bradley and Wildman (2002) noted that various factors, including parental history and child characteristics such as age and temperament, greatly influence parenting style. While parenthood poses psychological challenges for most individuals (Bell & Ainsworth, 1972), non-diagnosed parents typically exhibit warmth and support towards their children (Dallaire & Weinraub, 2005), despite finding parenting demanding and requiring sustained commitment (Nystrom & Ohrling, 2004). However, parents with BPD traits, characterized by reduced mentalizing capacity, may face heightened complexities in interpreting their infants' needs (Geerling et al., 2019). Eyden et al.'s (2016) review of quantitative studies on mothers with BPD revealed an increased risk of insensitive parenting (Hobson et al., 2009), corroborated by Boucher et al.'s (2017) findings of self-reported lower parental care and higher overprotection and inconsistency among BPD-diagnosed parents.

Parents diagnosed with BPD perceive parenting as both challenging and rewarding, often requiring more support compared to those with other psychiatric disorders, with an elevated risk of insensitive parenting (Petfield et al., 2015). Despite this, standard mental health treatments for BPD typically overlook parenting issues (Zalewski et al., 2015), necessitating a comprehensive examination of parenting experiences among BPD-diagnosed parents. Research-based on self-reports and interviews indicates that these parents feel less capable and exhibit lower self-esteem in their parenting skills compared to non-BPD parents (Ramsauer et al., 2016; Elliot et al., 2014). Moreover, parents with BPD commonly share themes with those facing severe mental illnesses, including stigma, fear of custody loss, and negative encounters with service providers, likely rooted in their personal histories (Zanarini et al., 1989), characterized by feelings of rejection, devaluation, and parental insecurity during childhood.

An increasing body of research employing self-report measures sheds light on the parenting experiences of individuals with Borderline Personality Disorder (BPD). Ramsauer et al. (2016) utilized self-report questionnaires, revealing that mothers with BPD perceive themselves as less competent parents, find child care more stressful, and do not derive satisfaction from raising their children compared to mothers without mental health diagnoses. Moreover, they reported feeling emotionally distant from their children and retrospectively acknowledged difficulty in understanding their children's needs. Similarly, Petfield et al. (2015) conducted a systematic review, finding that mothers with BPD exhibited reduced sensitivity, heightened stress, and poor mentalization capacities toward their children. However, their findings were constrained by small sample sizes. Eyden et al. (2016) corroborated these findings, adding that parents with BPD experienced heightened feelings of intrusiveness, overprotection, and hostility toward their children. These studies underscore commonalities between the experiences of mothers with and without BPD diagnoses.

Macfie et al. (2014) focused on mothers with BPD who had children of latency age, revealing feelings of insecurity, preoccupation, and unresolved relational issues with their latency-age children. Mena, Macfie, and Strimpfel (2017) found that parents with BPD exhibited higher rates of fear, frustration, and inconsistency in their interactions with their children compared to healthy mothers. Studies by Zalewski et al. (2015) and Renneberg & Rosenback (2016) employed clinical diagnoses of BPD, indicating that mothers with BPD reported higher distress and depressive symptoms, as well as elevated maternal emotion dysregulation and punitive behaviours compared to healthy controls. Kiel et al. (2017) observed that mothers with higher BPD traits displayed unsupportive parenting strategies, potentially influenced by a negative bias in perceiving their children's emotional expressions as angry and demanding. Additionally, some mothers reported interpersonal difficulties within their social support networks, leading to feelings of exclusion and stigma, potentially exacerbating their challenges in relating to their children. These findings raise questions about whether the difficulties experienced by parents with BPD extend beyond their relationships with their children, reflecting broader challenges in relating to others as suggested by theoretical frameworks. However, it is important to note that studies relying on self-report questionnaires may lack ecological validity and objectivity compared to observational paradigms, necessitating caution in interpreting their results. A comprehensive understanding of the parenting experiences of individuals with BPD is essential to grasp their impact on both the individuals themselves and their relationships with their children. In their comprehensive review conducted, Dolman, Jones, and Howard (2013) examined 23 qualitative studies involving 355 women grappling with severe mental disorders. These studies unveiled numerous emotional challenges faced by women upon receiving a diagnosis, including stigma, guilt, apprehension about potential custody loss, isolation, and struggles to fulfill maternal roles. However, it is important to note that the sample included a relatively low representation of women with Borderline Personality Disorder (BPD), limiting the evidence available concerning their unique experiences. This observation underscores the difficulties women encounter, with a diagnosis exacerbating their sense of isolation in society. However, only a few studies in the last 20 years have explored parenting perspectives among parents diagnosed with BPD.

Newman et al. (2007) examined parental self-efficacy and stress measures among 17 mothers with BPD. They found that compared to mothers without such a diagnosis, mothers with BPD experienced higher levels of distress, dissatisfaction in their maternal role, and poorer coping mechanisms. Elliot and colleagues (2014) interviewed 13 mothers diagnosed with BPD and assessed parenting stress and parental cognition and conduct toward the infant scale. They found that mothers with BPD scored higher on scales of overprotection and were less likely to perceive their behavior as impacting their children's development. However, these quantitative studies were limited in providing a deeper understanding of these parents due to the specific format and framework of the questionnaires used.

In one of the most recent studies on parenting among parents with BPD, Steele, Townsend, and Grenyer (2020) quantitatively examined how stress and competence are associated with trauma, attachment, and reflective capacity in parents with BPD. They studied 284 parents using multivariate analysis and found that parents with high BPD traits experienced more stress, lower competence in their parental role, more personality vulnerabilities, and poorer psychological well-being. They also reported more traumatic childhood experiences and had poorer reflective capacity. Steele et al. suggested that parenting stress and competence were associated with these vulnerabilities and that parents with high BPD traits might experience reduced stress and greater satisfaction in their role if they helped to increase their mentalizing capacities toward their children. However, due to the cross-sectional design of their study, strong conclusions about whether BPD caused parenting stress, difficulties in attachment, and reflective mentalizing capacities could not be drawn.

In Australia, Bartsch et al. (2016) conducted a qualitative study aiming to explore the lived experiences of parents with Borderline Personality Disorder (BPD). Employing thematic analysis on semi-structured interviews, they identified four key themes and seventeen sub-themes encompassing the challenges and rewards of parenting for individuals with BPD.

From their sample of 12 interviews, parents with BPD reported numerous challenges in parenting. They described difficulties in maintaining a stable environment and daily routines for their children, as well as struggles with establishing a stable social network and managing high-stress levels. Many expressed concerns about maintaining a safe environment for their children and acknowledged feelings of overprotection without fully realising the impact of their behaviour on their children's development. Additionally, most parents reported difficulties in managing interpersonal boundaries. One poignant quote from a parent encapsulated the theme of reliance on children to regulate emotions:

> *"I rely on the kids to try and calm me down. They are the parent, and I am the child. So when I get angry, I say, 'Why haven't you told me,' and they say, 'Mummy, I am listening. Calm down,' and then I will calm down" (Bartsch et al., 2016, p. 476).*

The poignant vignette illustrates a shared experience reported by some parents in the study, shedding light on their encounters with enmeshment and role reversal with their children. Furthermore, certain parents expressed emotional unavailability towards their children, primarily due to their distress, often prioritizing their needs over their children's. While parents diagnosed with BPD faced various challenges in their parental roles, the study also revealed several gratifying aspects of parenthood. They discovered that being a parent heightened their experience of positive emotions, such as love and pride in their children's development, and they cherished the opportunity to teach and guide them. Parenting was a powerful motivator for these individuals to cultivate healthier coping mechanisms and diminish self-destructive behaviors. This study provides a comprehensive account of how parents with BPD perceive their role as caregivers, derived from a meticulous thematic analysis encompassing their challenges and the rewards they experienced as parents. However, the study highlights the need for further research to explore fathers' experiences with BPD in their parenting journeys, as the current sample was small, making the generalizability of the results difficult.

In a study by Dunn et al. (2020), additional support and insights into the parenting experiences of parents diagnosed with Borderline Personality Disorder (BPD) in the United Kingdom were provided. The researchers interviewed 12 parents exhibiting BPD traits and 21 clinicians, revealing commonalities in the parents' experiences and the clinicians' observations when working with this particular group. The parents reported encountering several challenges in their role as caregivers, expressing that their mental health difficulties hindered their ability to parent as they desired. To cope with these challenges, many of them resorted to meticulously planning activities and daily routines to regain a sense of control. Similar to the findings of Bartsch et al. (2016), the study highlighted that these parents struggled with managing their intense emotions, impeding their capacity to respond effectively to their children's distress. Some parents also mentioned expressing anger or withdrawing from their children, exemplifying the complex emotional dynamics at play. One mother vividly described her experience, stating, "Then suddenly I find it makes me really irritable and angry, and then I am getting cross with her, and I am making it worse, and then it feels, oh my god, this actually this feels quite abusive, I am shouting and being mean to a child who is here actually having a panic attack." This poignant account captured the essence of several parents diagnosed with BPD, characterized by heightened emotions, intense and angry responses, and a diminished ability to address their children's emotions.

Alongside their emotional dysregulation, the parents described their journey through parenthood as arduous, using negative language to portray their experiences. Further exploration of this topic revealed that parents often perceived themselves as inadequate and believed they fell short of meeting their children's needs. They frequently employed terms such as "horrendous" and "a nightmare" to describe their parenting role, presenting a self-image tarnished by feelings of failure. The intensity of these emotions, coupled with low self-esteem and guilt, exacerbated patterns of self-harm and suicidal ideation.

Interestingly, many parents in the study attributed their struggles as parents to their own childhood experiences characterized by a lack of nurture and, in some cases, abuse. They connected their difficulties to the absence of positive parenting role models, expressing a desire to break the cycle and parent differently from how they were parented as children. Some parents, driven by this desire for change, exhibited overcompensating or overprotective behaviors towards their children. This study provided further elucidation on the challenging experiences faced by parents diagnosed with BPD in the UK. The illuminating vignettes presented in the paper and the parents' insightful reflections on their experiences highlighted their reflective capacity to draw upon their parenting experiences. It was evident that despite the challenges, all parents demonstrated love for their children. However, their struggles stemmed from a lack of nurturing experiences during their upbringing and subsequent emotional and relational difficulties. Similar to the previous study, the current research was limited by a lack of male participants and a small sample size. Nonetheless, these findings underscore the importance of further investigation into the parenting experiences of individuals with BPD.

A recent Australian study conducted by Geerling et al. (2019) contributes significantly to our comprehension of mothers diagnosed with Borderline Personality Disorder (BPD), particularly concerning the influence of their infants' crying on maternal well-being. This research project involved six mothers diagnosed with BPD recruited from a specialized mother-baby unit. The study revealed that mothers with BPD embarked on their motherhood journey in a vulnerable state and displayed heightened sensitivity towards physiological and emotional distress, often manifesting as a disordered response to their babies crying. By employing semi-structured interviews, the researchers delved into the participants' narratives, allowing for profound insights and detailed elaboration. Consequently, they identified five distinct themes. One predominant theme that resonated with all mothers was the prevalence of early childhood adversity. Reflecting upon their family backgrounds, these mothers could vividly recall the unpredictable and unsafe environment they grew up in. Consequently, severe attachment issues were evident, with one mother acknowledging, "I do not think there was a good attachment... she was kind of like cold; she did not want to deal with any emotions that were not positive or easy. My feelings were dismissed, or I was made to think they were wrong... felt ashamed; something was wrong with me. I usually withdraw, avoid, or do what they want" (Geerling et al., 2019, p. 412). This vignette encapsulates how these mothers recognised the complex trauma they endured as children and the subsequent emotional confusion stemming from dismissive parental figures. Consequently, the early experiences of their parents and the resulting emotional turmoil could help elucidate the subsequent theme identified by the authors as 'shock to the system.' All mothers reported feeling overwhelmed by their infants' crying, grappling with uncertainty regarding how to soothe their infants or cease the distressing episodes. They experienced profound emotional and physiological upheaval, often expressing distress, fear, frustration, anger, and helplessness, particularly when the crying persisted. One mother poignantly described the sensation of a "black hole in her chest" whenever her infant cried. These distressing and overpowering encounters contributed to cognitive chaos, representing another central theme identified in the study. Some mothers confessed to experiencing mental shutdowns in response to their infants' cries, impeding their ability to engage in mentalization or process information effectively. This mental withdrawal led to self-doubt regarding their role as parents, fostering negative self-perceptions of unworthiness and inadequacy in their maternal abilities. These negative ruminations often persisted incessantly and, in some cases, reactivated symptoms of posttraumatic stress disorder, further connected to the mothers' own experiences of an unsafe and distrustful childhood environment. The negative thoughts and emotions described above heightened the mothers' sense of isolation, with some individuals experiencing a fragmentation of their identity, perceiving only a fraction of themselves as capable of attending to their child's needs. Others resorted to mental shutdowns as a defence mechanism against overwhelming emotions. Additionally, some mothers employed psychological coping strategies such as aggression, avoidance, self-harm, and suicidal ideation to counter the distressing experiences of their infants' crying. Intriguingly, one mother found solace in her infant's crying, as it reminded her of her essential role as a parent, ultimately averting thoughts of self-harm. These defence mechanisms were pervasive among the mothers and perpetuated a 'domino effect,' exacerbating defensiveness, aggression, and paranoid ideation concerning others' judgments regarding their parental capabilities. Although the sample size was small, the findings presented in this study offer substantial material for contemplation and a deeper comprehension of the parenting experiences of mothers diagnosed with BPD.

The preceding studies primarily focused on mothers' experiences with their infants, leaving a significant gap in our understanding of fathers' experiences in such situations. In a ground-breaking qualitative study conducted in the UK, Lumsden, Kerr, and Feigenbaum (2018) explored fathers' experiences following a diagnosis of BPD. This study is the sole examination of its kind to date, making it a valuable contribution to the field. The researchers employed semi-structured interviews, engaging eight fathers as participants. Three overarching themes emerged from the data, each encompassing 3-4 subordinate themes. One central theme that emerged from the interviews was the ambivalence experienced by fathers upon becoming a parent. They described this ambivalence as a mix of fear and joy, acknowledging its significant role in their lives. While many fathers expressed excitement when confronted with challenging questions, they found it challenging to elaborate further. Some participants conveyed a sense of overwhelming responsibility and a feeling of being ill-prepared for caring for a child. Interestingly, one father articulated his ambivalence by admitting that he initially resisted bonding with his daughter due to concerns about the emotional difficulty of separation in the future. Another prominent theme, akin to findings observed in studies involving mothers, pertained to fathers perceiving their children as a source of motivation for positive life changes. However, this motivation was closely linked to fathers' perceived role as protectors and providers for their families, influenced by broader cultural expectations. Notably, one father mentioned that his child prevented relapse into negative behaviors. Additionally, a subordinate theme that emerged in line with previous studies on maternal experiences was fathers' recollecting their adversities during early childhood. They viewed their parents as negative examples, inspiring them to strive for improved fatherhood. All fathers reported grappling with overwhelming emotions, often leading to detachment and withdrawal, affecting their ability to be fully emotionally present for their children. Feeling a sense of absence, these fathers experienced shame for not living up to their expectations, associating it with societal stigma and perceiving themselves as "weak men." Their sense of shame was further compounded by the lack of contact with their children, intensifying their distress. Disturbingly, some fathers disclosed thoughts of suicidal ideation as a coping mechanism, expressing feelings of life being devoid of purpose. This study offers an initial insight into the unique parenting experiences of fathers diagnosed with BPD, thereby serving as a crucial and unparalleled contribution. However, it is essential to acknowledge that further research with a larger sample size is required to enhance the generalizability of these findings to the wider population of fathers diagnosed with BPD.

Parenting poses a myriad of challenges, with individuals diagnosed with Borderline Personality Disorder (BPD) often encountering heightened difficulties. Exploring the parenting journey within this group reveals a multifaceted landscape marked by numerous hurdles alongside occasional moments of profound connection and growth.

Research consistently underscores the significant impact of BPD on parental dynamics and roles within families. Emotional regulation, interpreting and responding to children's needs, and maintaining stable nurturing environments pose substantial challenges for parents with BPD. These struggles often trace back to their own traumatic childhood experiences, including neglect, abuse, or emotional instability, which deeply shape their approaches to parenting, compromising their internal parental models.

A striking finding is the pervasive sense of difficulty and distress experienced by parents with BPD in fulfilling their caregiving responsibilities. Qualitative research delves deeper into these struggles, shedding light on self-criticism, feelings of inadequacy, and compromised internal parenting models among these parents.

Moreover, gender differences in parenting experiences emerge among individuals diagnosed with BPD. Fathers grapple with expressing vulnerable emotions, while mothers face societal expectations of nurturing and caregiving (Warin et al., 1999; Diamond, 1995). These expectations, influenced by cultural norms, can both motivate and burden parents, contributing to their sense of inadequacy.

Furthermore, research underscores the intergenerational transmission of trauma and adverse childhood experiences among parents with BPD, perpetuating cycles of distress within family dynamics. Despite these challenges, glimpses of resilience and hope shine through as many express deep love for their children and a desire for better parenting experiences.

However, existing research has limitations, including small sample sizes and a focus primarily on maternal experiences. Future studies should strive for larger, more diverse samples, longitudinal designs, and inclusion of perspectives from fathers and other caregivers.

In conclusion, while parents with BPD encounter significant obstacles in fulfilling their parental roles, they also demonstrate moments of self-reflection and joy in parenting. Comprehensive support services tailored to their unique needs are essential in mitigating the adverse effects of BPD on parenting and fostering positive outcomes for affected families.

Addressing these challenges and providing holistic support can create a more nurturing environment for families impacted by BPD.

Gaps in the Literature

This area of research remains nascent, warranting further exploration to gain a nuanced understanding of the parenting journey among individuals diagnosed with Borderline Personality Disorder (BPD) and their children's perspectives. Current studies offer valuable insights into the challenges and experiences faced by parents with BPD, yet they often overlook the viewpoints of their children, representing a notable gap in the literature.

A significant avenue for future investigation lies in examining the specific parenting challenges encountered by children of different age groups. By focusing on parents with BPD across various developmental stages of their children, researchers can illuminate the distinct hurdles faced at different points in their parenting journey.

Moreover, there is a dearth of research on the parenting experiences of fathers with BPD, with existing studies predominantly centred on mothers. Recent acknowledgement of fathers' experiences underscores the importance of delving deeper into the unique challenges faced by BPD fathers in their roles as parents (Lumsden et al., 2018)

Furthermore, current research primarily emphasises the emotional impact of BPD mothers on their children, often neglecting considerations of physical development during early childhood. Attention to the physical well-being and developmental aspects of children raised by parents with BPD is imperative, especially given the high comorbidity of symptoms within this population.

Standard mental health treatments for BPD typically overlook parenting difficulties, as highlighted in previous studies (Zalewski et al., 2015). Therefore, conducting comprehensive investigations into the parenting experiences of formally diagnosed individuals with BPD is essential for informing the development of effective interventions. Future research could benefit from clinical BPD diagnoses, observations in naturalistic settings, and qualitative methodologies to capture the richness of these experiences.

Diversifying sampling approaches is another crucial consideration for future research endeavors. Current methodologies may inadvertently introduce biases due to predetermined standards and assumptions, particularly regarding cultural variations, gender imbalances, controversies, and stigma associated with BPD. Research across diverse cultures and contexts is essential to ensure validity and broaden our understanding of this complex issue.

In conclusion, there is an urgent need for further exploration into the parenting experiences of individuals diagnosed with BPD. By addressing these gaps and adopting a more inclusive and comprehensive approach, researchers can contribute to a deeper understanding of the challenges these parents and their children face, ultimately leading to the development of more effective interventions and support systems.

Conclusive remarks

In conclusion, the topic's significance lies in recognising that adults with Borderline Personality Disorder (BPD) often face a challenging journey into parenthood due to their history of adverse childhood experiences and potential difficulties coping with high-stress situations. As a result, their parenting approaches become more complex and demanding. To effectively support parents with BPD, conducting further studies that delve into their experiences is crucial, providing an in-depth analysis. This will contribute to a better understanding of their needs and inform future research and interventions. Importantly, such efforts can positively impact children's development, as early interventions may prevent the emergence of internalising and externalising mental health disorders. Additionally, by breaking the cycle of transgenerational trauma commonly observed in families with BPD symptoms, these interventions can potentially create lasting positive changes for future generations.

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Part 2: Empirical Research Project

Title:

Navigating parenthood: A qualitative exploration of the experience of mothers with a Borderline Personality diagnosis in a mentalization-based parenting programme

Word Count: 8283

Abstract:

Background: Having a Borderline Personality Disorder (BPD) diagnosis has been associated with challenges in parenting, with children of parents with a BPD diagnosis at risk of poorer physical and emotional development outcomes. However, the validity and use of this diagnosis are contentious. There is a need to understand more about parents' experiences with this diagnosis to understand their perception of their needs and find helpful ways to support them and their children.

Aim: To explore in depth the parenting experiences of mothers with BPD diagnosis who have children under the age of 3.

Methods: Qualitative interviews with eight mothers with a primary or secondary BPD diagnosis were analysed. These mothers were all enrolled on a mentalisation-based programme for which social services had referred them due to concerns about their parenting. The interviews were analysed using Interpretative Phenomenological Analysis (IPA), identifying major and subordinate themes.

Results: Mothers with BPD diagnoses enrolled on this programme had all experienced early adversity and trauma. This left them lacking internal positive parental role models. Early adversity also left them with anxieties and fears that contributed to experiencing negative intrusive thoughts about their parenting and what could happen to their children. Parents' current relationships with family members, friends and partners were difficult, and many felt isolated and lonely as parents, contributing further to their negative emotional states. Connected to their past experiences and current feelings of isolation, parents described struggles in their relationships with their children. They found it hard to set boundaries, felt overprotective, needed physical proximity, and experienced ambivalence towards their children. Yet, despite the challenges, they also found comfort in the developing bond between them and their children.

Conclusion: This research highlights, through the use of IPA, the need to further understand this vulnerable and often marginalised population to provide better and more helpful support to such mothers.

Navigating parenthood: A qualitative exploration of the experience of mothers with a Borderline Personality diagnosis in a mentalization-based parenting programme.

Introduction

Borderline Personality Disorder (BPD) is a complex mental health diagnosis. The American Psychological Association (APA) defines it as being characterised by behaviour and emotion processing and regulation difficulties. It is also considered connected to having unstable interpersonal relationships, mood instability, engaging in self-defeating behaviour that impairs social functioning, and extremes of idealisation and devaluation of others (American Psychiatric Association/APA, 2013). Fonagy and Luyten (2009) found high rates of psychiatric comorbidity in cases of BPD, showing the complexity of this diagnosis. However, it is also increasingly considered a controversial and inconclusive diagnosis (Campbell et al., 2020).

Theoretical aetiological paradigms emphasise a complex interplay between genetic and environmental factors. Crowell et al. (2009) biosocial theory of BPD refers to it as a 'disorder' arising from a maladaptive interaction between biological vulnerabilities and an invalidating environment. According to this theory, impulsivity and emotional dysregulation combine with invalidating parenting and negative early life experiences, resulting in adverse long-term social and cognitive outcomes. Fonagy et al. (2017) present a socially-oriented model of BPD, emphasising the role of a child's relationship with their primary carer in the first years of life. They support the idea that if non-verbal cues are absent, such as eye contact, protoconversations or turn-taking from the caregiver, the infant will develop defences of being constantly vigilant or closed off to communication, affecting their capacity to develop social knowledge and learn to relate to others. In Fonagy et al.'s model, this disengagement from others is believed to result in mentalisation difficulties and consequent emotional dysregulation. In both models, the child is viewed as experiencing poor understanding of their own and others' emotional states because their primary caregiver could not understand the child’s emotional states early on in life. This is believed to result in the child at risk of developing BPD or related symptoms in adulthood. BPD has been closely associated with adverse childhood experiences, including trauma, abuse and neglect (Bradley et al., 2005; Ball & Links, 2009; Porter et al., 2019), and maladaptive parenting has been shown to contribute to deficits in core emotional processes like emotional regulation and social cognition (Hughes et al., 2012; Winsper, 2018).

Having a history of adversity in early childhood, in turn, is believed to impact the individual’s parenting capacities in adulthood in an intergenerational cycle. The suggestion is that parents with BPD diagnoses are likely to enter parenthood with a complex history of adversity, a lack of an internal safe parental model, and potential deficits in their emotional mechanisms for coping with parenthood (Newman & Stevenson, 2005). Findings suggest that parental BPD increases children's risk of disrupted attachment and adverse outcomes (Newman et al., 2007). Several quantitative studies have found that BPD traits among parents are associated with reduced sensitivity, increased intrusivity towards their children, increased overprotection, and less competence. However, the value and validity of personality disorder diagnoses are increasingly contested. There have been serious critiques of the BPD diagnosis that emphasise its stigmatising, misogynistic and unreliable nature(Liu et al., 2023; Shaw & Proctor, 2005). Professionals may give this diagnosis to people considered ‘difficult to deal with’ or operating outside of the social norms (Sheridan Rains et al., 2021).

Despite the considerable research into the aetiology of BPD and adverse child and adult outcomes associated with this diagnosis, much less research has focused on parenting experiences among individuals with BPD diagnoses. However, a few studies, primarily based on quantitative self-report data, have found that parents with a BPD diagnosis report lower satisfaction in being a parent, increased stress in the parenting role, difficulties in the mother-child relationship, feeling more hostile and poorer mental health (Petfield et al., 2015; Eyden et al., 2016; Stepp et al., 2016; Boucher et al., 2017). In addition, Steele, Townsend and Grenyer (2020), using multiple self-reports, found that parents with BPD traits experience more stress and lower competence in their parental role and recollect more childhood traumatic memories. Although the findings of these studies also showed that parents with BPD traits had often experienced significant traumatic childhood events, the studies did not consider the impact of trauma on their experiences as parents. Although these studies provide important insights, the use of questionnaires and self-report data has limitations, and they do not provide as rich a source of information on parenting experiences as qualitative studies can give.

Only two to three studies have tried to understand how parents with BPD diagnoses understand and represent their experiences using qualitative methodologies. Dolman et al. (2013) systematically reviewed qualitative research on mothers with severe mental health issues and found only one paper that included mothers with BPD traits. Bartsch et al. (2016) explored perceptions of parents with a past or present BPD diagnosis. They included 11 mothers and one father and asked them about their experiences as parents. They used thematic analysis and found that parenthood was experienced as both challenging and rewarding. In some cases, they identified similar themes to studies with parents with other severe mental health disorders, such as fear of being stigmatised and losing custody of their children. However, they also found themes related explicitly to BPD. For example, parents described finding it difficult to maintain a stable environment, being physically unavailable because of their own difficulties, which made them also emotionally unavailable, connecting and attaching emotionally, and struggling to engage in play or child-centred activities. Some parents also reported intrusive and fearful thoughts of harming their children due to experiencing volatile and aggressive emotional states. On the other hand, parents also reported rewarding experiences in their relationship with their children. Some described how their relationship with their children gave them meaning and a purpose in life and how their children’s unconditional love meant everything to them. This strong feeling of having a purpose encouraged them to feel that they needed to teach and guide their children. Finally, Bartsch et al. (2016) identified that cultural ideas of how parents should be accepted as “good” parents significantly affected the experiences of parents with a BPD diagnosis, as they felt inadequate and different from what society wanted them to be, which often led to them feeling judged by professionals and hindered their sense of self as parents. Using thematic analysis, Dunn et al. (2020) echoed also Bartsch et al. (2016)’s results. They interviewed 12 parents of children aged between one to 34. They found that parents experienced stress and anxiety, which impacted their emotional states. They often felt isolated and lacked positive parental models to draw upon in their parenting. Furthermore, Geerling et al. (2019) explored qualitatively the impact of infant crying on mothers diagnosed with BPD. They used semi-structured interviews and interpretative phenomenological analysis (IPA). They found that mothers with BPD diagnoses entered parenthood in a psychologically fragile state, similar to what all other studies have shown. Because of this, the infant crying was experienced in a hypersensitive way, creating physiological-emotional pain and cognitive chaos. Their responses often suggested they were in flight-fight mode, including suicide attempts. Some mothers were seen to have what the researchers called ‘split identity’, where they could attend partially to the crying, but their ‘inattentive’ part could not cope with the crying.

The above studies give noteworthy insights to the experiences of parents with BPD diagnoses or traits. However, to date no studies have focused specifically on the experiences of parents with children in the first years of life, even though it is increasingly recognised that the this is a critical period, when the foundations of future development are laid (House of Commons Report, 2019). There has also been little research focused on the experiences of mothers with BPD diagnoses whose children are on the edge of care even though, as outlined, these parents are overrepresented in the children’s social care system (Neuman, 2012).

Understanding more about the needs of mothers' parenting in this context of vulnerability can provide important insights into the experiences of a group of parents rarely included in research. It can give voice to mothers who typically may be stigmatised and unheard, helping understand their needs to help improve outcomes.

The aim of the present study was therefore to understand the experiences of mothers with BPD diagnoses of caring for a child under three on the edge of care.

Methods

Study Design

This qualitative study utilizes Interpretative Phenomenological Analysis (IPA) as described by Smith and Osborn (2007). IPA's strength lies in its inductive and exploratory nature, making it ideal for delving into under-researched phenomena like understanding the experiences of mothers in a highly vulnerable state. This study specifically focuses on mothers attending a mentalization parenting intervention with children at risk of entering care.

The method's strength lies in its phenomenological-hermeneutical approach. This allows researchers to give voice to those mothers by understanding their lived experiences and the personal meanings they attach to them (Smith & Osborn, 2007). Simultaneously, researchers make sense of these experiences by interpreting how participants themselves make sense (Larkin & Thompson, 2012). This process is not objective; the researcher's own background and understanding influence the analysis. However, transparency about these preconceptions is crucial.

Ultimately, IPA facilitates in-depth exploration of shared experiences among mothers. It also allows researchers to identify both commonalities and variations within the group (Smith & Osborn, 2007).

Wider Context and Setting

This study was conducted as part of a wider evaluation of a specialist mentalization-based intervention that ran from 2011 to 2020. The intervention supported parents with complex difficulties with under-5-year-old children on the edge of care. Social services referred families, and the intervention's impact on their engagement and progress influenced custody decisions. Eligibility for the program required participants to be over 18 with a child under 5 and facing significant child protection concerns. While mental health diagnoses were not mandatory, many participants received a Personality Disorder (PD) diagnosis. This research was part of a larger project evaluating the intervention's effectiveness in a therapeutic community setting. The program aimed to help parents referred by social services due to severe child protection concerns safely care for their children. The comprehensive evaluation involved routine collection of qualitative and quantitative data throughout the intervention. Details regarding the broader evaluation's findings are yet to be published (Daum & Labuschagne, 2018).

Ethics approval for the wider evaluation was obtained from the University College London ethics committee (6821/001). Mothers gave written consent for the data to be gathered and analysed for research purposes. Participation was voluntary and all mothers were informed of their right not to participate or to withdraw without any negative consequences.

Participants

For this study, eight mothers were included from the wider pool of parents enrolled in the programme. They could have a range of mental health diagnoses or none, but many parents in the intervention group had received a diagnosis of Personality Disorder (PD). To ensure balance, we purposively sampled mothers who had a completed, transcribed PDI and for whom relevant demographic data was complete. These mothers had joined the intervention at different time points. They were included because they had all received a main diagnosis of BPD (n=8), and two of the eight mothers had received an additional diagnosis of BPD and had transcribed interviews at baseline (i.e. at the start of the intervention). BPD diagnosis was based on therapists'/clinicians' ratings, using the Shedler-Westen Assessment Procedure (SWAP, Shedler and Westen, 2007). As shown in Table 1, mothers' average age was 32, ranging from

21 to 47. Two of the mothers were of Black African ethnicity, five mothers were of Mixed White/Black Caribbean and one mother was White British. Each mother was referred by social services, and their children (aged 0-3 years, 4 boys and 4 girls) were at the edge of care. Six of the mothers were single, 2 were in relationships, and all had children under the age of 3. All mothers were given pseudonyms to preserve confidentiality.

Table 1

Characteristics of mothers with a diagnosis of BPD and their children

Name	Ethnicity	Main or Additional BPD diagnosis
Alisha	Black African	Main
Jasmine	Mixed White/Black Caribbean	Main
Kimberley	Mixed White/Black Caribbean	Main
Margaret	Mixed White/Black Caribbean	Main
Nora	Black African	Main

Ruby	White British	Main
Violet	Mixed White/Black African	Additional
Anna	Mixed Black African/White Other	Additional

Data collection

Qualitative data were gathered at the intervention's beginning, middle and end. However, this study focused only on the baseline Parent Development Interview (PDI). The current study focused on understanding the parents' experiences rather than the impact of the intervention. Therefore, only data collected at the start of the intervention were used.

The measures included in the analysis were the Short version of the Parent-Development Interview (PDI). Interviews were carried out by researchers working on the wider evaluation project or by clinicians, lasted roughly an hour and were conducted in a private room.

Measures

Parent Development Interview (PDI)

The PDI-R is a 45-item semi-structured clinical interview that delves into the parent's perceptions of their child, their own role as a parent, and the dynamics within their parent-child relationship. Throughout the interview, parents are encouraged to contemplate their child's emotions and thoughts across various scenarios, as well as their personal sentiments and reactions towards their child. Interviewers guide parents to provide illustrative examples giving a richer picture of their interactions with their child. Moreover, the interview encompasses discussing about the parent's own upbringing, identifying commonalities between their own experiences and those of their parents and exploring any instances of separation or loss within the relationship with their child."

Psychiatric Diagnosis

BPD diagnosis was based on therapists/clinicians working on the mentalisation-based intervention using the Shedler-Westen Assessment Procedure (SWAP).

Analysis

The interviews were audio-recorded, transcribed verbatim, and anonymized to ensure participant confidentiality. This study employed Interpretative Phenomenological Analysis (IPA) following Smith and Osborn's (2007) procedures. The analysis began with an in-depth immersion in the data. The researcher repeatedly reviewed each transcript alongside the corresponding audio recording. This iterative process aimed to capture the mothers' experiences through their choice of words and responses to specific questions. Following this initial descriptive phase, the researcher identified recurring themes and emotionally charged moments within the mothers' narratives. Particular attention was paid to understanding the connections and contradictions present in their answers. This step aimed to uncover the deeper emotional meaning behind their words. Utilising these insights, the researcher then developed emergent themes based on the mothers' language. The data were further interpreted in relation to the main research question. This involved examining relationships between themes within individual interviews and across the entire dataset. Subordinate themes with emerging connections were clustered to form overarching superordinate themes for each participant. This process aimed to capture the shared experiences and the unique aspects of each mother's journey.

To ensure the credibility of the analysis, the researcher maintained a reflective practice and documented field notes. This practice involved critically evaluating the potential impact of personal biases, perceptions, beliefs, and experiences on the research. To address further potential biases, an independent peer student pursuing a doctorate in child and adolescent psychoanalytic psychotherapy conducted a blind analysis of two transcripts. This analysis was then compared with the primary researcher's interpretation. While minor discrepancies emerged, they were discussed openly and brought to the group for further consideration. For instance, the theme of overprotection and controlling behaviour was initially identified. The peer researcher suggested reframing these traits as expressions of parental fear for the child's safety and in particular in the context of their children being at the edge of care, which possibly made the mother’s fears exacerbate. This valuable insight led to adjustments in the analysis and the integration of other valuable ideas from the peer student. This process ensured a faithful and meaningful representation of the data.

RESULTS:

Key Themes

Four key themes were identified from the data: *Haunting Past Experiences*, *Negative Emotional States*, *The good and the bad – Difficulties in integrating both,* and *Bodily States and the need for Physical Proximity*. These were also divided into subthemes (see Table 2). The themes were related to one another, so were not entirely separate or distinct.

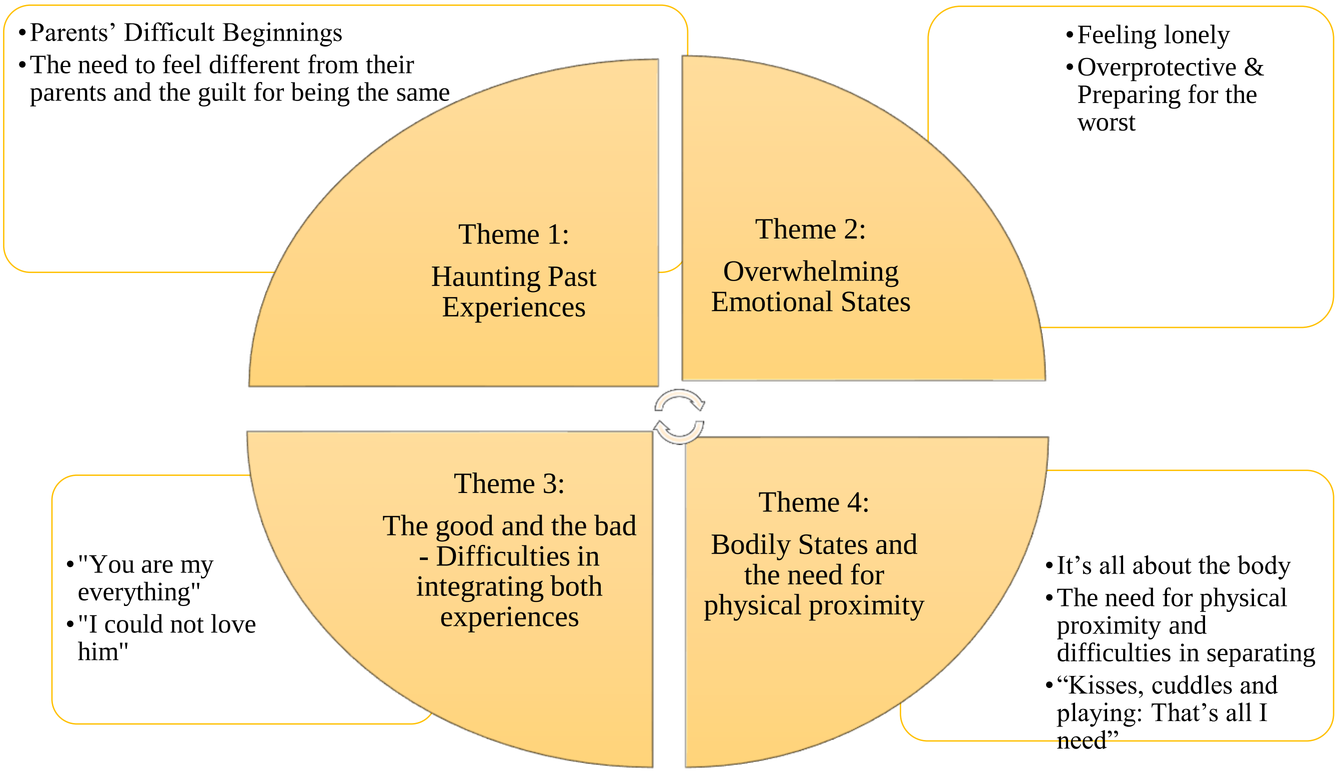

***Table 2**: Distinct themes & subthemes*

Haunting Past Experiences

<u>Parents’ Difficult Beginnings</u>:

A dominant theme identified in all mother’s accounts was the experience of childhood adversity, which left them lacking positive parenting role models. Jasmine, who herself had been adopted, recalled her difficult experiences in her family:

> *“I think life generally was just difficult with my adoptive mother because she was an alcoholic and would be shouting most of the time”.*

A number of mothers spoke of emotional, physical, verbal and sexual abuse in their childhoods, experiencing unstable and unpredictable family environments in which they felt unsafe and confused. Alisha and Violet described a lifetime of abuse and unpredictability as children:

> *"… you know my dad would tell me to go back to my mum, chuck me out so drag me on my hair and put me in the bus to go back to my mum … I go to my dad, he throws me out as well, I go back to my mum so I feel rejected". (Alisha)*

These inconsistent and abusive environments left mothers feeling rejected and invalidated. Ruby described feelings of insecurity and sensitivity in herself as a mother linked to her experience of not feeling safe or secure in her own family:

> *"Inconsistency. One minute, she would be really nice, and another minute, she would be really neglectful or cold, or her moods changed very quickly.- [I am]fucked up insecure, insecure neurotic insecure - insecure definitely um hm emotional over emotional um hm um sensitive. I'm very insecure with my family um I don't feel safe around them that's-, I've never really felt safe, there's something wrong."* (Ruby)

While Ruby spoke about wanting to be a consistent, safe and reliable presence of her own son, she felt her early experiences affected her ability to bond with him.

The need to be different from their parents and guilt for being similar to them:

Feelings of being unloved, rejected and abused created a strong desire in mothers not to be like their parents: they wanted to be different with their own children and to have different parenting qualities. However, all mothers, like Ruby, found their past experiences with their parents came back to haunt them in motherhood and were difficult to move on from. Similarly, Margaret expressed a strong wish not to be like her mother, yet recognised ways in which she was similar to her:

> *"(my parents) were very strict. I am like her (my mother) in the fact that I shout a lot, a hell of a lot. I don't want to. … (I feel so guilty) when I have to say no and then I get him what he wants and I feel really guilty". (Margaret)*

In this instance, Margaret describes several mothers' tensions due to their complex relationships with their parents. They described a feeling of guilt for perceiving themselves as similar to how their parents were to them, which could result in attempts to overcompensate. So if their parents were strict, like Margaret's, mothers would not be comfortable being strict with their children. However, the wish to be different from their parents could also prevent them from feeling able to set clear boundaries with their children for fear that if they did, they would traumatise them or act in the same way their parents did with them.

Jasmine, for example described how saying no and trying to set boundaries made her feel so guilty;

> *"I hate saying no to her. I love her, and saying no reminds me of how my mother was when punishing me. … I end up saying yes to everything she asks." (Jasmine)*

The unpredictable and abusive environments that mothers described early in their lives presented them with internal models of parenting that were confusing and rejecting and left them full of guilt for not wanting to be like their parents but feeling they were nonetheless like them in some ways. Their early experiences left them struggling to bond with their children. Ruby said;

> *"I found it very difficult to bond with him a lot, a lot of the time, umm. … so the difficulty with bonding with him would have been because of my experience as a child with my mother and my father to some extent and just the abandonment issues and the fact that I was left a lot to cry alone in a cot. (Ruby)*

Ruby's account shows how her memories and early experiences haunted her and continued to impact her parenting experiences.

Haunting experiences were described by all mothers and left them feeling persecuted by feelings of inadequacy in their parenting skills, or as one mother, Violet put it, fearing they were “not [the] best parent”. These haunting experiences could set in motion a spiral of overwhelming emotional states.

Overwhelming Emotional States

Several mothers presented with difficult accounts of their relationships with their role as mothers.

Feeling Lonely:

All mothers presented a feeling of loneliness and being on their own. Those feelings were experienced, especially when they felt low or had difficult moments with their children and needed someone to help them. Nora described her difficulties.

> “*Dealing with things on my own cause there’s only me, I’ve got no one to help me” (Nora)*

Similarly, Ruby also described a feeling of not having people close to her who could support her or help her. She recognised a need for someone to be there for her, to keep her company, and to support her emotionally.

> *“I wish I did not have to do so much on my own and that there was more people around. There are people around it’s just they’re not-, they are distant so they’re not-not always able to come and help out or just keep me company um, but it would make a big difference if they did” (Ruby)*

Violet and Anna were the only two mothers in relationships, yet they also described feelings of loneliness and feeling they could not share them with anyone. For example, Violet explained:

> *"I'm kind of like, feel a bit lonely you know and that and I don't know how to speak to him about it. And stuff like that and I'm really worried. I have been wanting to speak to someone. I felt so alone. I've been feeling alone. I've been feeling. I'm thinking what should I do, should I end it, should I do this? Should I go sleep with someone and not- A lot of things are going through my mind" (Violet)*

Overprotective & Preparing for the worst

Mothers sometimes connected their feelings of being alone to experiencing intrusive negative thoughts about something bad happening to them or their children. For example, Margaret described her struggles when her children were asleep and she was alone, saying:

> *"It's at those times when I am not busy and alone, intrusive bad thoughts come to my mind that something bad will happen". (Margaret)*

Most mothers described having intrusive negative thoughts about themselves and their circumstances. Some mothers' intrusive thoughts also made them feel overprotective towards their children, preparing them for the worst. Violet illustrated how such intrusive thoughts could make her feel very low;

> *"I just- sometimes I have a drink. Umm sometimes I get so depressed and wrapped up in my own thoughts and feelings and stuff. ... I fear losing her. I- I fear like uh I think all these things." (Violet)*

It seems likely that mothers' fears around loss may have been exacerbated not only by their challenging past and present circumstances but also by the context of their involvement with children's social services. Alisha, for example, described experiencing overwhelming fears about someone taking her child away, and not being able to protect him:

> *"I just think that someone is gonna come in my house and take him or someone is gonna do something to me or I am gonna die or something is gonna happen to me and then he is gonna be left in the flat just screaming by himself and I just have overwhelming feelings on daily basis that stuff is gonna happen. (Alisha)*

Another mum described how she had racing negative thoughts constantly:

> *"I feel like I am beating myself up all the time. Just constantly, my head just goes round and round even when my sons is around"(Kimberley)*

Due to their negative thoughts, the feeling of not being good parents worsened, making mothers feel guilty. That guilt would turn into punitive thoughts towards themselves and catastrophic thoughts that something terrible would happen to their child. Violet described her fear of losing her young child.

> *"I fear of losing her. I- I fear like, uh, I think all these things like is she gonna fall out the window or even if [I] have a bad dream about falling out the window and all that." (Violet)*

Due to those fears and anxieties from intrusive negative thoughts, mothers described needing to protect their children constantly. Some mothers also described themselves as overprotective, like Nora, who described herself as *"very protective, need always to know where she is"*.

The good and the bad – Difficulties in integrating both experience

During the interviews, it became evident that each mother alternated between idealised descriptions when discussing their relationships with their children and expressing a lack of emotional connection during moments of negativity and distress. In these latter instances, they depicted their relationships with their children as less than perfect. This dual portrayal, wherein each mother shifted between idealisation and denigration, highlighted the ambivalence in their feelings towards their children. Nonetheless, it is important to consider that these ambivalent feelings could be understood within the context of the challenging situation they faced; entering an intervention where their parenting skills were being assessed, a circumstance that likely contributed to their mixed emotions.

“You are my everything.”

At times, mothers described their children as perfect and perceived them as saviours.

> *“Oh my god, yes if it wasn’t for (child’s name). I wouldn’t be here today not to, I’d not be here today he is giving me life again, you know, he is you know.”* (Kimberley])

Nora described her little girl as everything to her, fulfilling all kinds of roles and needs unmet by other people in her life.

> *“She’s my everything, like she’s my daughter, my love, she’s my best friend, she’s, she’s everything to me, she’s my dad, she’s my brother, she’s everything”* (Nora)

Margaret also described how having a child had made her develop and mature.

> *“It’s made me grow up a lot. It’s made me understand a lot in-, like within myself and things. It has, umm it definitely tames me a lot. Made me grow up and mature.” (Margaret)*

Both mothers talked about how much their children made them develop and grow and that they were the reasons that kept them alive. For some parents' children seemed to represent and fulfil other missing relationships.

“I could not love him.”

At other times, mothers would describe difficulties with bonding with their children. Kimberley described how her negative intrusive thoughts and her guilt prevented her from feeling connected with her child.

> *“Even when I was first started here, I felt pretty much on the floor, you know. Very low, very emotional, not fully attached, you know what I mean, like I should be. I was taking care of him, but I wasn’t loving him as much as I should have been, sitting with him, you know and holding him like I do when I am well. ... You know my mind was constantly racing just thinking of negative, bad things and feeling guilty because feeling guilty looking at (the child). And feeling guilty then for a short period wishing that I just didn’t have to have him to take him out,”(Kimberley)*

Kimberley continued with a detailed description of feeling something was wrong, making her feel very guilty. Her constant pressure to care for her child and her difficulties in doing so created a strong inner conflict that made her always think negatively. During those times, intrusive negative thoughts and her inner conflict felt unbearable.

On the other hand, Violet and Anna, who had BPD as an additional diagnosis, presented with a more integrated view of their relationships with their children. They described both frustrations and rewarding experiences with their children and seemed to hold a more integrated view of the bad and the good times they had simultaneously. As Violet said:

> *"But umm yeah to be honest yeah it's frustrating, it's rewarding. It's a whole load of things, you know, umm, being a parent, but I wouldn't change it. I wouldn't change [child] and that. Umm, what do I think? It's very, very fulfilling.* **(Violet)**

Bodily states and the need for physical proximity

The final dominant theme that most mothers presented with was the idea of their children not understanding emotional states or feelings, seeing them only as having bodily needs but not emotional needs. Mothers presented with a real need to be physically close to their children and described difficulties separating from them. At the same time, however, this closeness revealed a side of playfulness and much-needed physical interaction for the mothers and their children.

"He is only two; he doesn't feel yet."

When asked about the impact of their emotional states on their children, most of the mothers said that their children do not understand emotions because they are very young. They also focused a lot on the more physical demands of their toddlers, like being cleaned and fed. Kimberley said;

> "*He is content when he is fed and cleaned (laughing). Yeah, that's how I would describe him; he is very easily pleased. And they are the three things as long as he is fed ... and he's got a clean bum, he is happy." (Kimberley)*

Nora also described the more physical aspects that her toddler needed in order to be satisfied and happy, rather than reflecting and thinking of her baby as feeling and having emotions;

> *"... feeding her, changing her nappy, uhh physical stuff. Upset? However, she's still a baby; she can't be upset, but if she needs something, she will let me know." (Nora)*

Although most of the mothers presented this idea of their children as only concerned and preoccupied with bodily states, dismissing the idea of babies and toddlers having emotions, Ruby seemed more able to think of her baby and described her as a creature with emotional needs and mental states, sensitive to his environment. Ruby's reflectivity perhaps partly stemmed from the researcher who was interviewing validating her experiences more. She could connect her toddler's emotional sensitivity with his bodily states and the interrelation between them.

> *"…very sensitive to noise and very sensitive to my moods and his dad's moods. That's- if I'm anxious, he will notice straight away, um and when he, when I was going through a period of crying a lot, it got to stage where he was actually looking at me if I just did it, mucking around made a crying noise 'wahhhaha' he would look at me to say mummy shut up now I have had enough of it. So he's very aware and very sensitive. Maybe aware would be a better word". (Ruby)*

<u>The need for physical proximity and difficulties in separating</u>

Most parents described in different ways how they needed to be physically close to their children and how their children reflected that. Margaret described a sense of loss and missing her child, revealing also the difficulties she experienced in separating from him.

> *"Like when he goes to nursery, I'm just like well where's my little sidekick? Like, where's he gone? Like I feel lost without him. Like I just love him so much, and he definitely feels the same about me." (Margaret)*

Nora described a similar experience from her child's perspective:

> *"And then, but obviously I can't resist her, I do pick her up after a while, but I don't like to hold her like I used to all the time, as in like when she's eating, I'm holding her, she falls asleep in my hands."* (Nora)

Nora and Margaret described a sense of missing and needing to be very close to their child, finding it difficult to separate. Kimberley's account suggests this could come from a fear of feeling left out and not needed anymore: she described very vividly her fear of not being important as her child grows in independence;

> *"I don't want him to get too independent 'cause I want him to need me, do you know what I mean? I want him to want me in his life. But I do like it; I feel proud of him." (Kimberley)*

Similarly to Kimberley, Alisha described how if her child became independent, they might hurt themselves, presenting a fear that if she is not with her child constantly, her child might be in danger or do something dangerous.

The two mothers with BPD as an additional diagnosis seemed more able to reflect on the positives of separating because of their children growing up. When asked what she finds brings her most joy in being a parent, Violet gave a qualitatively different account to Kimberley's saying;

> *Just seeing my daughter growing up. Seeing how she's developing. Seeing you know. Umm, having the memories and things you know. (Violet)*

Mothers presented with a real need to be physically close to their children, which led to anxieties about separation but also provided them with a positive experience and helped them to feel more attached and bonded to their children

Kisses, cuddles and playing - "That's all I need."

Most mothers showed much warmth when describing playing and being close to their children. Kimberley described how being further away and coming back together to cuddle created enjoyment in both.

> *"That was just lovely, do you know what I mean? I don't know, I can't explain it, he just laughs and comes back to me, comes back to me, then he comes up at me, cuddles and, you know."* (Kimberley)

Similarly, Jasmine described a loving moment when she was giving a bath to her toddler. They both played, and she found this an essential moment of positivity in their relationship.

> "*She was in the bath, and she put all the bubbles all over and on my face ... she was really laughing, and I was laughing too."* (Jasmine)

In addition, Margaret said;

> *"He loves to be tickled. Like when I go (raising my hands and approaching him), he knows (the tickling) it's coming. And yeah, we do like quite a lot as a family ... it's always laughs and smiles."* (Margaret)

All the descriptions above show the importance of the physicality aspect in playfulness, which is appropriate for this age. Violet described such experiences;

> *"And I give cuddles, and I tickle her everything, and yeah, we do play a lot together, and I sing to her and stuff. That's why that's-, that's fun."* (Violet)

This sense of closeness and being together with their children gave parents a sense of belonging and meaning, which was missing before having their children. This was one of the prevalent themes for most mothers, showing another side of the relationship between mothers and children and the need for physically being together.

Discussing Reflections

This qualitative study explored the parenting experiences of mothers with main and additional BPD diagnoses and their under-3s children on the edge of care. The IPA methodology allowed for an in-depth exploration of parenting experiences, and their narratives provided details of their emotional and behavioural experiences. Both challenging and rewarding experiences were described, and while differences between parents were identified, they also had considerable shared experiences. Four main themes were identified, though these were overlapping, dynamic and constantly interacting with each other: 'Haunting past experiences, Negative emotional states, The good and the bad - difficulties integrating experiences, and Bodily states and the need for physical proximity. A particular novel theme of this study is the "Bodily states and the need for physical proximity", which has not been identified by other studies before.

The theme "Haunting past experiences" showed that all mothers had experienced early trauma, adverse childhood events, and severe neglect. In previous studies, most parents with BPD diagnosis have experienced early adversity, impacting their attachment, emotional and cognitive development (Petfield et al., 2015; Geerling et al., 2019). Current models explaining BPD stress the relationship between each individual's personality disorder and early adversity, calling for a rename of such disorder as complex post-traumatic personality disorganisation (Herman, 1992). This could have the advantage of encouraging future research to focus on the history of the trauma and the difficulties that people with BPD present with, such as emotional dysregulation and the difficulties in the relationships they develop. Linehan's and Fonagy et al.'s models seem to support the idea of an individual's early trauma and history interacting with a genetic predisposition, resulting in personality development difficulties (Cicchetti & Rogosch, 2001). Newman and Stevenson (2005) have stated that those early traumas that have not been resolved continue to operate in adult relationships, either as re-enactments or reparative attempts to change disturbing relationship dynamics. The lack of positive parenting role models left them confused, unsafe, invalidated and feeling rejected in their parental roles.

Overall the theme is reminiscent of Fraiberg et al.’s (1975) paper, ‘Ghosts in the Nursery’. The metaphor of ghosts refers to the unremembered past of the parents, likening them to uninvited guests. The authors observed a pattern in which parents were overwhelmed by their own past experiences, leading to a pathological identification with their internal parental figures. This psychological defence, described by Anna Freud (1936) as "identification with the aggressor," is a defence mechanism used by these parents to cope with their internal and real persecutory parental figures. On the one hand, they sought to be similar to these figures, while on the other, they expressed a desire to be different, as reported by mothers. Those early haunting experiences made those parents enter motherhood already fragile (Geerling et al., 2019). Consequently, several patterns of difficult experiences in parenting were described in their relationships with their children. They described severe guilt stemming from their desire to diverge from their parents' behaviors, yet simultaneously recognized many recurring traits within themselves. Freud (1914) underscores the unconscious tendency of individuals to compulsively repeat aspects of disturbing events as a means of coping emotionally with trauma. These reparative efforts aimed at altering past tumultuous relationship dynamics, especially within the context of their current relationships with their children, potentially contributed to the development of some maladaptive coping strategies. Due to immense guilt, most mothers overcompensated by not placing adequate boundaries on their children because they feared being perceived by their children as punitive. This led to difficult situations; most mothers struggled to bond with their children.

In the realm of their encounters, and often amidst a dearth of social support, mothers frequently characterise the journey of parenting as solitary and isolating. They grapple with intrusive negative thoughts, envisioning dire scenarios involving themselves or their children, a relentless and daily occurrence. This narrative brings to light Williams' (1997) notion of 'double deprivation', where parents initially suffer from external circumstances beyond their control, followed by an internal deprivation stemming from their psychological defences and the inadequacy of their support systems. Building upon this, Emanuel (2010) introduces the concept of 'triple deprivation', illustrating how the challenges faced by parents and children in care reverberate within organisations, effectively paralysing social service systems and yielding disoriented responses.

Understanding these experiences is crucial, especially considering that these mothers are on the brink of intervention, with final decisions looming regarding the custody of their children. This precarious juncture can intensify feelings of disarray and fear rather than providing the stable foundation needed for them to focus on their children's well-being.

These mothers have been described by previous studies already experiencing 'cognitive chaotic thoughts' which are most likely influenced by exposure to early adversity, neglect and disruptive attachment patterns in childhood (Streeck-Fischer & van der Kolk, 2000). These intrusive thoughts created an anxiety that something terrible could happen to their child at any moment. This follows other studies that describe the emotional and cognitive turmoil of mothers with BPD diagnoses due to their trauma, indicating that chaotic and early adversity distorted their reflective capacities (Geerling et al., 2019). For some mothers, this unbearable feeling was exacerbated and resulted in immense guilt for having thoughts of not wanting to have their children. To deal with this strong internal guilt, some mothers overturned this feeling, presenting with the need to always prepare for the worst, being hypervigilant and overprotective around their children. This is also in accordance with research that supports the idea that parents overcompensate by being hypervigilant and overprotective, feeling that they provide safety to their children and overturning in that way their past experiences of being parented (Beebe & Lachman, 1988; Bartsch et al., 2016). Trauma research suggests hypervigilance acts as a maladaptive coping mechanism for what may happen when living in a chaotic, unstable, traumatic environment where attachment figures are abusive and neglectful (Nelson et al., 2020).

Parents had difficulties holding an integrated view of their experiences with their children. All parents were oscillating between idealisation and denigration of their relationships with their children. At times, they would identify their children as their saviours and at other times, they described feeling low and having difficulties connecting emotionally with them. Mothers often grapple with an overwhelming sense of guilt when acknowledging the presence of challenging emotions toward their infants. Winnicott (1949), in his seminal work 'Hate in the Countertransference,' articulates this sentiment and elucidates numerous reasons why mothers may experience feelings of animosity toward their babies. He extends this analysis to therapists, exploring why they too may harbor feelings of hatred towards their patients. Central to his argument is the portrayal of the infant as 'ruthless' towards its mother, treating her as "scum, an unpaid servant, a slave" (p.74), simultaneously eliciting both excitement and frustration. He further contends that denying these ordinary emotions can lead therapists and mothers alike to feel disconnected and struggle to engage effectively with their patients or children. These difficulties could make mothers shut down or dissociate when confronted with overwhelming experiences. Otto Kernberg (1975) stated that the defence of splitting has attained a special importance in borderline personality organisations, describing it as a dissociative state. Splitting defence is used when those mothers feel under pressure, which compartmentalises the experience when mothers cannot integrate a mixture of emotional experiences such as fear, stress, happiness, anger or enjoyment. This occurs because the individual's emotional state is overwhelmed and lacks the capacity to deal with emotional pressures. In order to cope, it splits its experiences, either idealising or devaluing both their internal emotional states and the idea of their children.

A novel theme in this study is the “Bodily states and the need for physical proximity”. All mothers with BPD as a primary diagnosis showed difficulties accepting and understanding their children as emotional beings. Closely linked with those mothers' negative intrusive thoughts, perhaps parents found emotional aspects of their children’s relationship difficult. Overwhelming emotional experiences impair their mental capacity for emotional insights into how their children might feel (Fonagy and Luyten, 2009; Dunn et al., 2020). The difficulty for emotional insight was also shown in Geerling et al.’s (2019) study, which explored the impact of infants’ crying on mothers with BPD diagnoses and found that mothers felt overwhelmed. Their copying mechanism was to “split their self”, attending only to the physical needs of their babies in a practical way and avoiding the emotional experiences. Similarly, in this study, there is an overarching theme of those mothers being preoccupied with their children’s bodily functions, expressing the view that their children are not old enough to experience emotions. One way to understand this is by examining the ways in which parents' overwhelming and traumatic experiences split their sense of self, leaving them without internal models to integrate their children's bodily and emotional needs and their own experiences as parents. This can compromise their ability to fully engage with the rewarding and challenging aspects of parenting. Perhaps in some ways, it is understandable that those mothers were focusing on the physical development of their children because it feels less overwhelming. Another explanation is that, as Hnatiuk et al. (2013) suggest, children of such age experience their environment primarily through their bodies. Might such mothers pick up on this and focus as well on the body functions rather than the emotional aspects?

On the other hand, attachment theory on mother-child separation research suggests that when mothers are both emotionally and physically available to their children, the child can hold and develop a belief in their minds that the mother is available when needed and secure attachment is formed (Bowlby, 1973; Ainsworth, 1990; Kobak & Madsen, 2008). This appeared more evident in the other two mothers who got a BPD diagnosis as a secondary one. They were able to reflect and describe the relationship as both challenging and rewarding and to recognise their children's bodily and emotional needs, too.

Another aspect of this novel theme is that most mothers found comfort and a sense of security through physical closeness with their children, unlike Bartsch et al.’s (2016) study, which showed difficulties engaging in playing interactions. This is a positive moment for their interactions with their children, which could underlie anxiety and insecurity due to their fear that something might happen to them if they are not close to each other. As all mothers described, a coping mechanism for this would be to be close to their children, which could, at least on the surface, show those mothers might find separation difficult. In addition, mothers with BPD have been heavily criticised for their difficulties relating to their children and their lack of mentalising capacities and emotional insights (Fonagy & Luyten, 2009; Dunn, et al., 2020). On the other hand, Bowlby (1969) suggested that consistent care and closeness over time give rise to affectional bonds. The playfulness and physical closeness they seek with their children play a vital role in bonding and feeling a purpose in their sense as parents. This unique theme in this qualitative research needs further exploration and understanding as to the impact and the reasons underlying the need for physical closeness and the overprotection and difficulties in separation themes.

This is the first qualitative study to explore the specific experiences of mothers with BPD who have under3s children, using IPA methodology. Using the clinical diagnostic tool for diagnosing BPD in mothers with children of this specific age group was a strength. Previous studies have called for researching mothers' experiences with children in different age groups, adding to the body of knowledge.

Strength and Limitations

A dearth of studies have explored qualitatively the experiences of mothers with BPD diagnoses who have children under 3 on the edge of care. The IPA methodology facilitated an in-depth explorations of their experiences.

Nevertheless, there were several limitations of this study that need consideration before generalising findings to a wider population. It is important to acknowledge that this study is part of a larger study involving parents who had been referred by social services to a specialist mentalization-based intervention. Consequently, it is essential to understand the findings in this context, recognising for example that the views of participating mothers may not represent a direct reflection of their experiences, and could have been influenced by social desirability bias: in particular, mothers may have felt under scrutiny for their parenting skills or feared adversely affecting clinicians' decision-making around their children and this could have affected their responses in various ways.

This model of analysing data provides rich themes derived from looking at each participant's accounts in depth. For this reason, sampling in this study is small, which is not unusual for IPA studies (Smith et al., 2009). The sample for this study was very distinct, including mothers who entered a community intervention program with children under 3 at the edge of care. It is unknown if the results can be generalised to mothers in other contexts. The socio-cultural make-up of participants was also striking. Most mothers were mixed Carribean or Mixed/Black African and only one mother was White British. Bywaters et al. (2016) have found that Black mothers might be overrepresented in social work proceedings, while other research has questioned whether mothers from Black, minoritised or deprived backgrounds may also be more likely to attract a diagnosis of BPD and face discrimination within services (Bacon et al., 2023; Dubriwny, 2010; Sweeney & Lever Taylor, 2019). Further research is needed to better understand the influence of sociocultural status in this context. A wider cross-section of participants which should also include fathers would also increase generalizability as most research to date has focused on mothers (Newman et al., 2007). Another limitation was the different researchers/clinicians that did the interviews which could have evoked different responses in the individuals if, for example, the researcher was more or less validating the mother's experiences and emotions, which could either make the participants open up or close down. Also, the mothers might be at different stages in their lives and some could have received more support than others before joining this community intervention. Thus some of the differences in the reflecting capacities between the parents could be because of attending other interventions previously.

Implications and recommendations

If replicated there are a number of implications for clinical practice and research. Firstly, understanding the role of trauma on the parenting experiences of mothers with BPD diagnoses is vital. Clinicians working with such mothers also need to be aware of how social services' involvement may increase pressure on mothers, affecting their parenting and behaviours towards their children (Mason et al., 2020). Clinicians working with this population need to provide a validating and safe environment where such mothers are more able to discuss their struggles. Psychoeducation on babies' and toddlers' emotional and physical development might be useful in parallel with an intervention as developed by Sprengeler et al. (2021), suggesting short-term psychodynamic parent-infant/toddler psychotherapy. In addition, the importance of parent education on child development and infant and early childhood mental health (IECMH) could help parents understand social-emotional development in these early stages. Such interventions could include for example the Circle of Security, Circle of Parents and Touchpoints, helping parents attend to both the bodily and emotional experiences of their children and strengthen the attachment between them. Furthermore, due to mothers feeling isolated and lonely, strengthening their support networks seems important.

It is important though, to acknowledge that certain experiences described in this study, such as feelings of loneliness, separation anxiety, and the need for physical closeness, are emotions and experiences that might be universally shared among many parents. Consequently, interventions tailored to address these common experiences could potentially offer applicability and benefits to parents coping BPD as well.

Conclusion

In conclusion, this study provides insights into the parenting experiences of mothers with BPD diagnoses and their under 3 children on the edge of care. Early adversity appeared to have a significant impact on mothers who entered parenthood already haunted by past experiences. All mothers felt isolated in their role as parents and described negative intrusive thoughts, along with intense anxieties of bad things happening to them or their children. This sets in motion a dynamic interplay of overwhelming guilt, difficulties in integrating idealising or denigrating experiences of their children, overprotection and needing to feel physically close to their children in case something bad happened to them. In addition, they found it difficult putting in place boundaries, and at times regarded their children as compensating for other relationships mothers found they were lacking or found it difficult to develop and maintain. The majority of mothers focused heavily on the physical needs of their children, rather than seeing them as emotional human beings. However, mothers also found much comfort in being physically close to their children and this could help the developing bond between mother and child. Mothers' anxiety, fear of losing control and mechanisms of overprotection should be considered also in the context of these mothers being on the edge of care with the fear of losing custody of their children experienced as a catastrophic consequence for them. We found that having children's social care exacerbated parents' anxieties and distress and, for this reason too, services need to consider how best they can support this population in a trauma-informed way.

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Part 3: Reflective Commentary

Word Count: 3624

Shaping the ground with steps and slopes – A search for an integrated identity:

In this account, I will describe my reflections on the research component of my doctoral training in Child and Adolescent Psychoanalytic Psychotherapy. I intend to portray both the challenging and rewarding experiences of the research and the clinical work through the account of my thoughts and feelings, which I gradually became more aware of as I was writing this paper.

Through the challenges and rewarding experiences I faced, I could search for, develop and build on my identity as a researcher and clinician. Through the struggles of the first two years, the research slowly became more embedded in my thinking than I had initially anticipated. Henton and Midgley (2012) acknowledge the split of the worlds of the researcher and clinician. Those splitting processes invade one's capacity to integrate. In this reflective commentary, I will try to portray how this occurred in the initial training phase, where splitting felt necessary for the integration to occur over time. The marriage of research and clinical practice became possible through the interchange and integration of research and clinical identities through the various seminars and different t (Henton & Midgley, 2012).

In this reflective piece, I narrate my experiences searching for and developing my identity as a clinician and researcher and the challenges of integrating the two. I will describe the various stages I went through for the 'maturational process' and the integration (Winnicott, 1984). I will offer a narrative around my experiences, hoping to bridge those often cited splitting aspects.

Between the Cyanean Rocks:

In all the years of the training, in the morning, trainees are expected to attend the Anna Freud Centre for research-related modules and in the evening to join the British Psychotherapy Foundation (*bpf*) for clinical seminars and workshops. The physicality of going to two different places in the first year created a splitting in my mind on the different experiences that each place held. In addition, I spent most of my time at my clinical placement based in a Looked-After's Children and Adolescent Mental Health Service (CAMHS) in South London. All those different places perhaps added to my confusion and increased the splitting in my mind. When starting my training, my primary focus was on clinical practice, with research taking the back seat. Upon reflection, both my identities as a child and adolescent psychotherapist in training and as a researcher were still in their infancy, which created anxiety and feelings of fragility, which were compounded by being at the beginning of my training. This fragility in the first year increased my anxieties and splitting processes, feeling the need to preserve and protect at least one of those parts of my professional identity. This increased my desire to be loyal to my clinical work and disparage the research aspect, which I experienced as holding all the 'badness' of my experience in training (Klein, 1946).

In the first year of the training, the research component included attending a Research Methods module, conducting a service-based research project (audit), inventing a research proposal as an oral presentation, and attending a Journal Club. All those processes helped me prepare to take a written exam at the end of the first year. At the beginning of the training going through those research modules felt like a frightening thing to immerse myself into, as I was trying to focus on developing my clinical identity. The intensity of the research on Tuesday mornings made it feel that research was imposed on us, but as attendance was necessary to move to the second year of the training, I had to try at least to engage in it. It is essential to mention that I had worked as a research assistant in several qualitative and quantitative projects before the training. Although at the time, I was holding and preserving the part of me that wanted to be a 'good' clinician and alienating the research side of the training (Klein, 1946; 1952).

The combination of the Research Methods, the audit and the journal club modules strengthened my skills in descriptive statistics and reminded me how to approach research papers. More specifically, the research methods and the journal club modules allowed me to read new research and understand further developments in methodology, which paved the way for starting to think about the topic of my audit. I also had the opportunity to discuss my ideas with the team in my placement and try to understand what would be helpful for my team to do an audit on. At the same time, the task felt complex and unclear because there was no clear guidance at the beginning. Brainstorming and exchanging ideas with my fellow trainees on their audit subjects was helpful. At times the combination of the audit and my increasing amount of clinical work made engaging with the audit even harder. This was mainly because of how new I was feeling to all this and jumping between the role of the researcher and that of the clinician.

Reflecting back, these research components remained a helpful introduction to understanding how to go from big ideas to specific smaller questions and feel that this is adequate for the service. The audit of the research proposal made me aware of how the simplest and smallest questions are usually a good way to start when approaching research. This is a skill that I could provide in my next job opportunity, and I would be interested in doing further small audits.

During the first two terms of the first year, research felt quite out of touch with clinical practice. Although reflecting back, I could see the benefits; research felt like an impossible task at the time. As illustrated in the title, at the beginning of the training, the clinical and research components felt like the Cyanean Rocks' and anything between them would crash, making it safer to choose one side and perhaps not sail through them. Gradually engaging increasingly with the research component, I found my 'dove'-hope and the emotional risk of crossing what felt such a dangerous path was more imaginable. Retrospectively, I can think of what I learnt from those modules as transferable skills. However, it was not until later that I could appreciate that those modules and the regularity of the research teaching at the beginning of the training set the foundation blocks for combining the two professional identities. These paved the way to make me feel engaged with the following research modules and later with my research topic and thesis, which required some skills to navigate through.

Skin and Bones: Forming a Body of Thought

In the third term of the first year, preparing for the oral presentation was a valuable experience. It was an engaging activity. I learnt how to share ideas, make an argument and prepare an idea from scratch with a group of people. At the time, I felt the usefulness of research based on clinical experience in CAMH services. I employed my knowledge of working in CAMHS and my creativity to think of how to approach specific patient groups, engage them in research, and employ different methodologies in attracting funding for a hypothetical scenario.

Furthermore, I learnt the importance of looking at the literature, identifying the gaps and narrowing it down to one specific question addressing that gap. It was an important exercise that was challenging and, at the same time, rewarding. This module made us think about the literature review and the next steps for our research. This activity was very engaging and helped me shape my audit question and move forward with it.

Reflecting on the end of the first year, we were also asked to select a topic that would form the basis of our research topic and influence our literature review. I recalled having to choose from three topics. One was exploring and looking at specific themes/topics emerging from therapy sessions of adolescents with depression from the IMPACT study (Midgley, Ansaldo & Target, 2014). Another option was to look into data about adoption and the matching process. Last but not least, it was about looking into data from the Early Years Parenting Unit (EYPU) at the Anna Freud Centre (AFC), and more specifically, the parenting experiences of parents with complex trauma and their under 5s.

Choosing a topic felt like quite a significant decision as we were handed projects that the AFNCCF had already identified. On the one hand, this created a sense of security, knowing that experienced researchers had identified those research areas. On the other hand, my worry was how to make those predetermined and already chosen topics/‘babies’ my own - how could I claim them? Reflecting on my clinical work with Looked-after children and how at times, they felt unclaimed, I wondered what processes I might have to experience to claim the final project as my own, perhaps ‘claiming my baby’ (Baradon, Biseo, Broughton, James and Joyce, 2015).

Multiple factors influenced the process of choosing a topic that would engage me. While being stuck in this process of indecisiveness, one of my inspirations came from having the experience of attending a psychiatric placement. At the end of the first year, all trainees had to visit an adult in-patient ward for one term for 4-5 hours per week. This brought me into contact with disturbing aspects of the human mind, specifically the experience of ‘madness’ in adulthood. At the same time as the psychiatric placement, I continued seeing my patients. The combination of the two made me wonder about the experiences of my patients living with their birth parents, who had experienced chaotic and unpredictable environments. Questions emerged in my mind about how they coped, the impact of parental mental illness and its effect on them. The possibility of being involved with the EYPU data to look at a specific population of mothers and their under5s felt like something I was curious to look at. In my clinical work, I could see the impact of trauma on the relationship between birth parents and their children. Winnicott’s (1965) ideas on impingement, trauma and the effect of the environment on development helped me to imagine some of the internal struggles of people with trauma. I was yet to see how that could be translated into research. Hence, I was keen to gain some understanding of the parenting experiences of parents with mental health issues and an idea of the environment of children at the edge of care. Thus my choice of subject for my research followed naturally from this. In addition, in light of my previous experience in research and completing the first year of my training, I was trying to hold onto the importance of the qualitative methodology, which

Bachrach (1995) described as the essence of psychoanalysis, wanting to develop my qualitative skills further.

Freedom of being in movement:

The beginning of the second year of training required further decisions on the literature review. Learning through the intensity of the research modules in the first year, I put what I had learnt into practice to develop and create my idea. In the second year, the regularity of the research modules decreased. However, independent study time and group and individual supervision were provided to give us the space to develop our thinking and specific questions for our literature review. Although, it also felt more chaotic and overwhelming, as I recall having many ideas. My supervisor was a catalyst in this process. She allowed me to have many thoughts and ideas and gradually decide on one specific question. In the literature review, I wanted to bring the child's early experiences to the fore and focus on the environment's impact on their physical development.

My clinical practice inspired my literature review. I saw a latency boy, whom I will call George here for confidentiality. George presented with psychosomatic issues, and his emotional presentation was that of a toddler. As I had previously worked with under5s, I was reminded of the importance of bodily experiences at that age. At a similar period, I was also reading a lot about parenting experiences and under5s, to help me think about a more specific question for my research. I noticed a gap in psychology and developmental research regarding the impact of trauma and impingement on the physical development of young children. I had come across several papers from French psychoanalysts and clinical psychologists on the importance of the body. Tardos and David (1991) consider body movements as the foundation of the individual's body image, and the children's motor activity brings out the subjective experiences.

Moreover, Roussillon (2008, p.90) supports the idea that free and spontaneous activity is “the first experience the child has of himself being, of feeling himself being”. This made to wonder about parents with personality disorders may have an impact on the physical and, more specifically, on the motor and gross development of their child. Perhaps, similarly, my supervisor allowed me to move in between my thoughts and develop my own experiences of being without feeling closed down or rejected. Gradually, skin and bones were taking the shape of a whole body with too many thoughts that my supervisor-environment could contain and guide me through.

I remember presenting the primary task of my literature review in group supervision with all my co-trainees present. The main question was to explore the parenting experiences of parents with Borderline personality disorder (BPD) and the impact on their children’s physical development. The feedback was that my question was still too big and broad. It seemed that I had presented them with two questions. Thus, I had to leave something behind and choose between the two, which was a struggle. I had to leave behind a part of the research I was particularly interested in. With the help of my supervisor, I chose to look into the parenting experiences of parents with BPD, also thinking that my research thesis would be informed significantly by this review.

A Researched Body

In the third year of training, with the main research topic refined, a new challenging period lay ahead. Upon reflection, although in the first two years, I was not fully aware of how both my experience in research and clinical work would define my thinking, I formed my research question drawing on both. This was to look in depth at the parenting experiences of parents with BPD and their under3s. Winnicott’s (1963) ideas about the impact of the environment on development influenced me and helped me develop my ideas further. I realised that I had gone through many diverse and different experiences until then that formed my clinical and research professional identities. The third year proved to be the year where I could integrate the two. Perhaps I could only understand in the third year how the doctoral training had provided a facilitated environment before this year and go through what Winnicott (1984) calls the ‘maturational process’. In Year 1, the research modules were frequent and provided an environment in which we were more dependent on our teachers and supervisors. Moving to Year 2, we gradually developed our independence through individual and group supervision and more independent study time for our literature review. In Year 3, we were given individual supervision that was quite frequent. The research structure reminded me of Winnicott’s reference to a facilitating environment that allows us-infants-trainees, to move from dependence to independence and from part experiences to Ego-integration—this facilitated integration of both being a clinician and a researcher.

At this time, I had to put all my knowledge and skills into practice, choosing the data to be analysed and deciding on an analysis method. From skin and bones, my literature review significantly shaped and informed my research question, taking a proper shape and form. I recall feeling excited and eager to listen to interviews and immerse myself in the data to grasp and understand the parenting experiences of mothers diagnosed with BPD.

My literature review helped me to feel confident that I knew the past literature well and could now move to develop my ideas around methodology. I remember deciding with my supervisor that we would choose eight interviews of mothers who had been diagnosed with BPD at the baseline of joining the EYPU program. I remember feeling quite uneasy with the diagnosis that those mothers were getting, as the diagnostic label does not reflect each individual's unique experiences. This made me more determined to understand the experiences of such mothers. After careful research and thought, I decided that Interpretive Phenomenological Analysis (IPA) would be the most suitable analysis method. This method was used because it provided the opportunity to explore unique experiences and understandings of how parents perceive and make sense of the phenomenon of parenting and caring for their under3s children. Secondly, this methodology had not been used previously in any other study on this topic, even though it gives us an in-depth understanding of parents' experiences. I recall a sense of worry and a struggle in my thinking of wanting to immerse myself in the data and how time-consuming this process would be. I was worried about how to voice each mother's struggles and rewarding experiences, how to do justice to those troubled mothers that quite a few in the literature described as controlling and hard to engage. Upon reflection, another struggle in immersing myself in the data when listening to and reading the interviews was not allowing the knowledge I gained from previous research on this population to colour my experience.

Moving to the data analysis, I realised the importance of listening multiple times to each recording and reading transcripts repeatedly. This helped me to put my feet in the mothers' shoes, although it also painted a painful reality of the tormented experiences that those mothers had from their thoughts and feelings of not being "good enough". All mothers referred to their experiences of abuse and neglect as children, revealing their difficult upbringing. I connected both views in my mind, holding a more integrated idea of some children's upbringing and early life experiences and understanding what their birth parents might have experienced. This interplay between experiencing and learning through the data was a valuable insight into what some of the children I saw at the time had gone through.

Supervision provided an invaluable source of containment for analysing the data and writing the results section, guiding my thinking and constantly bringing me back to the participants' material. This also became invaluable to my clinical psychoanalytic technique. From a clinician that found joy in the interpretative work, I became more what Winnicott (1969) described, and I quote; "If only we can wait, the patient arrives at understanding creatively and with immense joy, and I now enjoy this joy more than I used to enjoy the sense of having been clever. I think I interpret mainly to let the patient know the limits of my understanding. The principle is that it is the patient and only the patient who has the answers." My supervisor helped me invaluably stay with the data and transfer this knowledge to my clinical practice. I was developing a more explorative stance and closely followed the unfolding material of my patients rather than interpreting it to feel 'clever'.

Before entering the fourth year, the data analysis and the write-up of my research thesis were completed after a long and thorough process. My qualitative research competencies developed and proved clinically relevant and valuable in helping structure my thinking according to emerging themes. The fear of losing your child or the rewarding experience of playing with your child resonated with the fears of adoptive parents I worked with and their difficulties sometimes in engaging with and playing with their children. How could one think and approach such issues? With the help of my supervisor and other teachers that provided a containing presence, I reflected on my clinical work and thus of providing a facilitating environment to my patients to help them grow, understand and explore their emotional world by staying close to the material they were bringing.

Growing to a Body of Conclusions - Enjoying one's capacity to create:

Overall, I had not anticipated the importance of the struggles and the rewarding experiences in doctoral clinical training. Initially, the research and the clinical components of the training felt split. Although the beginning always seemed difficult, it was through feeling an internal splitting and then developing through these struggles that one could begin to feel ready to sail through the internal Cyanean Rocks. Gradually with the regularity of the research modules, research felt more possible. The various engaging activities and group work facilitated the integration of the research slowly into the clinical identity. In addition, slowly feeling safe in the professional identity of the clinician, one could start reaching towards the identity of a researcher, getting into the mud and the messiness, and shaping the foundations. The facilitated environment provided by the university, colleagues, supervisors and teachers allowed me to move from being dependent and slowly grow an independent mind: a mind where I could still move between my many thoughts and ideas and where emerging interests slowly began to take the form of a rudimentary structure of skin and bones. With the close guidance of my supervisor and the feeling of safety, I could create a research question that achieved the research task and engaged me in deep learning, where the maturational process could take place. This maturation and inter-exchange between those identities that collide will continue to occur. However, the marriage of those aspects of professional identity in the doctoral training has given me the appreciation of having a bag full of tools I can use and transfer into my next professional and personal journeys.

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