Experiences of parenting in mothers who have a diagnosis of Borderline Personality Disorder: An exploratory study

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Abstract

Background

Previous research has investigated the experience of having a mental health diagnosis and being a parent. However, there is very limited research that examines the experience of being a mother with a diagnosis of Borderline Personality Disorder (BPD). The current research that is available around parenting with this diagnosis focuses on outcomes of children to these parents and the difficulties that people with this diagnosis may have with parenting. The lived experience is lost within the current literature.

Method

This study utilised a qualitative methodology, Interpretative Phenomenological Analysis, to explore the experience of being a mother with a diagnosis of BPD. 5 participants were interviewed using a semi-structured interview schedule.

Results

3 superordinate themes were identified from the data that were common for most participants: being a bad mother, needing to be understood and accepted by children, and lack of support. 7 subordinate themes are also outlined and discussed. There were a number of similarities and differences within participants' experiences.

Conclusions

Further research that investigates how experiences may differ depending on the age of the child would be interesting. This study found a number of similarities with the current available literature on experiences of parenting and having a severe mental health difficulty. However, a number of differences to the literature were found in this study, suggesting that there are key differences that need to be kept in mind when considering the experiences of mothers with a diagnosis of BPD.

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Table of Contents

List of tables and figures

Appendices

Chapter 1: Introduction

1.1 Overview

Borderline Personality Disorder (BPD) is a relatively common diagnosis, with approximately a 4% prevalence rate in the general UK population (Coid, Yang, Roberts, Ullrich, Moran, Bebbington et al., 2006). It is a diagnosis that is predominately used in Western cultures although the pattern of difficulties commonly diagnosed as BPD are thought to occur globally (Swartz, Blazer, George & Winfield, 1990). The majority of those diagnosed within a clinical setting are female (Skodol & Bender, 2003) and there is a growing body of research investigating how having a mother with a diagnosis of BPD can impact on a child (Stepp, Whalen, Pilkonis, Hipwell & Levine, 2011; Macfie & Swann, 2009; Apter-Danon & Candilis-Huisman, 2005). However, there is a significant gap in the literature regarding the experiences of motherhood in individuals with a diagnosis of BPD. Interestingly, this is not the case with other mental health diagnoses. While a recent systematic review identified a number of studies that investigated the experience of motherhood and severe mental illness (Dolman, Jones & Howard, 2013), this review only identified one study that included mothers with a diagnosis of BPD (Savvidou, Bozikas, Hatzigeleki & Karavatos, 2003), whom made up 10% of the sample. This indicates the need for further research in this area.

This chapter will outline the clinical presentation and features of BPD and provide an overview of the current literature of theoretical and

etiological models that describe the development of BPD. The existing

literature on parenting and mental illness will be discussed, as will current

ideologies of motherhood. The clinical presentation of BPD and how this

may relate to parenting will be described, evaluating current published

research. The present study will then be outlined in relation to the previous

research.

1.2 Clinical presentation of BPD

BPD is a clinical diagnosis in which the individual is seen to have a

pattern of instability in interpersonal relationships, instability of self-image,

and marked impulsivity (Diagnostic and Statistical Manual of Mental

Disorders, 4th edition, DSM-IV, American Psychiatric Association, 1994).

Individuals with BPD may have difficulties with emotional regulation and

may self-harm (Kuo, Korslund & Linehan, 2006). It is a diagnosis that is

also associated with an increased risk of recurrent suicidality (Kessler,

Borges & Walters, 1999) and completed suicide, with research showing

rates of between 9-10% suicide completion (Paris, 2002). Individuals with

this diagnosis often have other co-morbid mental health difficulties such as

depression, anxiety, and substance misuse (Kendell, 2002). Research into

the course and onset of BPD has suggested that certain symptoms associated

with BPD decrease over time (Stone, 1990). Although BPD cannot be

diagnosed before the age of 18 in the UK, there is evidence that symptoms

that are commonly associated with BPD may be present during adolescence

(Chanen, Jovev, McCutcheon, Jackson & McGorry, 2008). Research has

also shown that younger adults with a diagnosis of BPD significantly differ in clinical presentation to adults with a diagnosis of BPD (Morgan, Chelminski, Young, Dalrymple & Zimmerman, 2013).

1.3 Theories of the development of BPD

The clinical presentation of BPD and the use of the diagnostic label has led to the development of models that hypothesise why and how this pattern of clinical difficulties may develop in individuals. Most models of the etiology of BPD include both biological and environmental components.

A number of research studies have explored a possible biological explanation of BPD. A review by Belsky and de Haan (2011) investigated the interaction between childhood trauma and brain development. The authors concluded that childhood maltreatment and deprivation can have an impact on brain structure, suggesting that environmental factors can influence biological structures.

One study estimated the heritability of BPD as 65% (Torgersen et al., 2000). This suggests some degree of tangible influence of genetics in BPD. Other studies have questioned whether there is a genetic link for BPD by exploring whether BPD is more common in families where another member has this diagnosis and some research has indeed suggested that personality traits associated with BPD can be inherited (New & Seiver, 2002). This could mean that children of mothers with BPD might also be more likely to develop these personality traits although it is not possible to

know whether this is genetically inherited or as a result of parent-child interaction. Macfie & Swan (2009) concluded that children who have a parent that is diagnosed with BPD have been shown to display similar behaviours to their parent. However, again it cannot be determined whether this suggests a genetic link for BPD or whether this behaviour developed as a result of parent-child interaction.

Within Dialectical Behaviour Therapy (DBT) BPD is conceptualised as developing in the context of an emotionally unsupportive environment in childhood, in combination with underlying, possibly biological, emotional vulnerabilities (Heard & Linehan, 1993). It is true that many people with a diagnosis of BPD report abusive experiences in their childhood, neglect, or significant separation or loss of a caregiver (Laporte & Guttman, 1996; Zanarini, 2000). Studies have compared the early experiences of those with this diagnosis with other psychiatric samples and 'healthy' controls; the finding of these studies consistently show that those with a diagnosis of BPD report higher rates of childhood sexual, physical and emotional abuse (Weaver & Clum, 1993; Spitzer, Effler & Freyberger, 2000; Sansone, Gaither & Songer, 2002; Bandelow et al., 2005). Rogosch and Cicchetti (2005) looked at whether any precursors could be identified to the development of BPD. They commented that maltreatment appears to be a common factor when investigating whether a child displays precursors of BPD. Verbal abuse in childhood has also been related to the development of personality disorder in adolescence or adulthood (Johnson et al., 2001). Research suggests that the difficulties with regulating emotions that people with a diagnosis of BPD experience are linked with this early trauma (Van

der Kolk, Hostetler, Herron & Fisler, 1994; Winston, 2000). This early unresolved trauma is also linked with self-harm and the experience of dissociation (Herman, Perry & Van der Kolk, 1989).

People with a diagnosis of BPD may have difficulties forming attachments with others due to negative experiences in childhood. In their attachment-based model, Fonagy, Target and Gergely (2000) proposed that individuals with a diagnosis of BPD commonly have a disorganised attachment style. This suggests difficulties in recognising, labeling, and understanding mental states in themselves and others (mentalisation), as it is proposed that this develops as part of the attachment process in childhood (Fonagy, Gergely, Jurist & Targey, 2003). When children have a secure base, they are able to explore the world whilst feeling safe and can explore and learn about their caregivers mind and their own mind. The caregiver labels emotional states for the child so that they can learn to do this for themselves (Fonagy, 2000). If the caregiver does not do this or a child experiences their caregiver as hostile or threatening, the infant does not learn how to label these states in themselves or in others as a defensive response (Agrawal, Gunderson, Holmes & Lyons-Ruth, 2004).

Infants develop internal models of the self and others that function as templates for later relationships (Agrawal et al., 2004). These models then guide expectations and beliefs about past, present, and future relationships. These processes may have been disrupted in childhood for people who later go on to have a diagnosis of BPD meaning that they have a disorganised attachment style because of the inconsistencies in caregiver response. BPD has also been described as a disorder of self-development

and a disorder of self-regulation, due to people with this condition reporting feelings of emptiness, mood swings, impulsivity, and dissociation (Macfie, 2009).

The behaviours that individuals with a diagnosis of BPD often present with can be explained by attachment theory. Gunderson (1996) suggested that insecure patterns of attachment—specifically, pleas for attention and help, clinging, and checking for proximity—closely parallel the behaviours of those seen in individuals with a diagnosis of BPD. The Dynamic Maturational Model (DMM; Crittenden, 1995) of attachment explained that, "danger, including especially frightening danger, organizes self-protective behavior as survival mechanism" (Crittenden & Newman, 2010, p.435). Crittenden (1995) suggested that danger can then either be resolved adaptively or can remain as an unresolved trauma. The DMM considers both loss and separation, like in traditional attachment theory, but it also considers various forms of abuse (Crittenden & Dallos, 2009). In individuals with BPD, we can hypothesise that traumas often remain unresolved and that within the DMM, an individuals response to perceived danger is a self-protective strategy (Crittenden & Dallos, 2009).

One of the dominant treatment models for BPD, DBT (Linehan, 1993), suggests that the core deficits that those with a diagnosis of BPD posses are difficulties with self-regulation and distress tolerance. Any emotional regulation skills that people with this diagnosis do have can be difficult for the individual to access because of personal biological and environmental factors (Dimeff & Linehan, 2001). Within DBT, there is a model for how the disorder is maintained in that biological and

environmental factors are thought to interact so that an individual's more dysfunctional emotional regulation strategies are reinforced and more adaptive emotional regulation strategies are punished (Shearin & Linehan, 1994). The environment can also invalidate the individual's emotional experiences, maintaining the disorder (Linehan, 1993).

A recent study by Lyons-Ruth, Bureau, Holmes, Easterbrooks and Brooks (2013) examined symptoms associated with BPD and suicidality in adolescents. Whilst the study did not state whether the parents of the children that took part had a diagnosis of BPD or not, this longitudinal study showed that disturbed parent-child interaction during infancy was predictive of suicidality and borderline symptomology in adolescence. Interactions were assessed using videotapes and self-report ratings. The authors note that early maternal withdrawal was particularly key within this. This suggests that early parental behaviour may have an impact on the development of BPD.

1.4 The experience of having a diagnosis of BPD

The difficulties that are part of the clinical presentation of BPD are likely to impact on many aspects of an individual's life, such as how they are treated by other people. Indeed, numerous studies have focussed on the personal experiences of individuals diagnosed with BPD, in relation to their diagnosis.

Whewell, Lingam and Chilton (2004) discussed a reflective group that they ran which allowed individuals to discuss the experience of having BPD. Group members reported feeling that they were often misunderstood and defined by others in terms of their diagnosis. Participants also felt that they were often unable to present their 'true self' to other people. Fear of abandonment and a feeling of emptiness was also common amongst group members. Other key experiences discussed within this group were depression and suicidal feelings, intense feelings of anger, impulsivity, dissociation, self-harm, childhood trauma, and relationship difficulties (Whewell et al., 2004). Holm and Severinsson (2008) conducted a literature review that looked at the distress and emotional difficulties that women with a diagnosis of BPD report experiencing. The researcher's reported three themes across the qualitative literature: emotional abuse and neglect during childhood, emotional management difficulties leading to self-harm, and social difficulties due to difficulties with emotional regulation. It is discussed that women with BPD seem to conceal or suppress the emotional distress that they experienced during childhood. Perseius, Ekdahl, Asberg and Samuelsson (2005) found that individuals with BPD reported struggling for their health and dignity within the context of this emotional pain that derives from childhood trauma. Participants also reported that living with BPD felt like 'life on the edge'.

Chapman, Specht and Celluci (2005) investigated self-harm within people diagnosed with BPD. Participants in this study reported that self-injury was used to escape from unwanted emotions. Welch and Linehan (2002) found that social problems were often an important factor in self-

injury. Nehls (1999) conducted a qualitative study about living with the diagnosis of BPD. This study found that individuals reported that they had limited access to care resources and felt that they were perceived as manipulative.

It is clear from the literature that the personal experience of having a diagnosis of BPD can be challenging. The research referred to above describes the personal difficulties resulting from the clinical expression of BPD, but also the way that perception and treatment of someone with this diagnosis can be problematic. The above research also indicates that individuals with BPD have often experienced childhood trauma and, as previously discussed, it has been suggested that these traumatic experiences may contribute to the development of BPD. It could also be suggested that childhood trauma compounds the challenges of living with a BPD diagnosis, in terms of memories of this contributing to ongoing emotional distress. It would seem that childhood experience, clinical presentation, and societal responses are all factors that are likely to have an impact on how an individual with BPD makes sense of their experiences.

1.5 Stigma and professional attitudes

Some of the research discussed above identified that people with a diagnosis of BPD often report the experience of being perceived and treated negatively by others, including health services and professionals. A qualitative study conducted by Fallon (2003) found that individuals with a BPD diagnosis reported experiencing negative attitudes from health staff

15

and being made to feel undeserving of care. These findings have been substantiated in research that has looked at professionals' attitudes to BPD, with staff reporting that they find individuals with a diagnosis of BPD more difficult to care for (James & Cowman, 2007). Research has also shown that health professionals perceive individuals with a diagnosis of BPD to be more dangerous and are less optimistic in terms of outcomes for this group, in comparison with other psychiatric diagnoses (Markham, 2003). Another study showed that mental health staff believed people with this diagnosis to be deliberately sabotaging treatment or trying not to improve (Bland & Rossen, 2005). Nehls (1998) found that some staff reported that they feared being manipulated by individuals with a diagnosis of BPD and that this impacted on the care they provided.

When considering the experiences of an individual with a diagnosis of BPD, it is important to be aware of the stigma and negative attitudes that surround this diagnosis. These experiences are likely to be affected by other roles that the individual has, such as being a mother. It could be hypothesised that a parent with a BPD diagnosis might experience additional stigma in comparison to an individual with no parental responsibilities. This will be discussed further in section 1.10.

1.6 Criticism of the diagnostic label

A number of researchers have questioned the usefulness of BPD as a diagnostic category, both in relation to the stigma associated with this label and whether it is clinically accurate. There have been questions raised about

its reliability or validity as a diagnosis (Becker, 1997; Francis & Widigen, 1987). Due to people with this diagnosis often having experienced past trauma, it has been argued that people with this diagnosis could essentially be diagnosed as having Complex Post Traumatic Stress Disorder (C-PTSD) rather than BPD (Hodges, 2003). McLean and Gallop (2003) reported that most of the women in their study who had a history of childhood sexual abuse met criteria for both BPD and C-PTSD, suggesting that they may not be two distinct diagnoses. Shaw and Proctor (2005) state that a diagnosis of C-PTSD acknowledges the traumatic experiences that women with BPD have often been subject to, where as the label of BPD does not.

The label of BPD has been criticised as being a diagnosis based on gender bias. Men displaying similar difficulties are more likely to be diagnosed with anti-social personality disorder where as women are more likely to be diagnosed with BPD (Simmons, 1992). Feminist arguments, such as those from Wilkins and Warner (2001), have discussed that individuals difficulties should be located within their past traumatic experiences rather than within the self. Lester (2013) argued that BPD does not exist within the individual nor would the symptoms cease to exist if the diagnostic criteria were no longer present. She stated that "BPD is a disorder of relationship, not of personality" (p.74, Lester, 2013). It has been argued that individuals with a diagnosis of BPD learnt to behave in certain ways in order to survive abusive experiences, and that by labelling this as a disorder it is pathologising survival attempts (Warner & Wilkins, 2004). Shaw and Proctor (2005) have also contributed to this argument and have stated that women with these difficulties should be viewed as survivors of

17

abuse and that their responses to this abuse should not be pathologised due to this gender power imbalance. When these women's past experiences are considered, behaviour can often be viewed as meaningful and adaptive. Viewing BPD as an internal condition can mean that the individual's experiences are not taken into account or understood as the symptoms are viewed as separate when they are not considered in context (Warner & Wilkins, 2004).

Crowe (2004) has argued that BPD could be conceptualised as an overwhelming shame response as individuals with this diagnosis have often experienced events that are strongly associated with shame, such as childhood sexual abuse. Rusch et al. (2007) also found that women with a diagnosis of BPD reported more explicit and implicit aspects of shame than a control group of women with no diagnosis and women with a diagnosis of social phobia. Crowe (2004) provides further evidence for this idea by providing extracts of interviews with women that have a diagnosis of BPD. In these interviews, it is clear that the women feel a deep sense of shame towards themselves and their behaviour. It is discussed how viewing these difficulties as part of an overwhelming shame response would impact on intervention strategies, and potentially lead to more effective support for these individuals.

BPD as a diagnosis has negative connotations and has been described as a 'blaming' label in comparison with other diagnoses (Lewis & Appleby, 1988). Individuals with a diagnosis of BPD are often construed as being manipulative and the cause of their difficulties seen as having an internal locus of control (Markham & Trower, 2003). Mental illness, within

the medical model, is normally construed as being external to a person (Berrios, 1993). However, the label of personality disorder implies that there is something intrinsically wrong with the individual's personality, and implies an element of self-control (Blackburn, 1988). Crowe (2004) also argues that personality may not be fixed and stable but that the label of personality disorder assumes mental disorder if this is not the case.

Despite these problems with diagnosis and labelling, BPD as a diagnosis is still widely used and continues to be included within diagnostic manuals, and the majority of mental health services in the UK are structured to include separate specialist services for people with a diagnosis of personality disorder. The term BPD was first used in the DSM-III in 1980 and measures and diagnostic interviews have been developed that claim to reliably distinguish BPD from other psychiatric disorders (Gunderson & Kolb, 1978). Gunderson (2008) has argued that BPD seems to be separate to other psychiatric disorders but acknowledges that there can be an overlap. He states that there are four marked features of BPD: unstable and intense relationships, fear of abandonment, a feeling of emptiness, and affect instability. Gunderson (2008) discussed that BPD as a diagnosis is clinically useful for both patient and clinician in order to establish prognosis and a treatment plan. It could be argued that because BPD is often viewed as life long diagnosis this may not instil hope in either the individuals that are given this diagnosis or clinicians. However, some individuals report that they feel validated by the diagnostic label as it helps them to feel understood (Whewell et al., 2004).

Despite this criticism, it is useful to understand how people with this label make sense of their experiences. As this research plans to explore the experiences of being a mother with BPD, it is first appropriate to consider the research regarding mental health and parenting in a wider context.

1.7 Parenting and mental health

As parental behaviour can impact on a child's development it is important to consider how mental health difficulties can impact on parenting and vice versa. Women with mental health difficulties are just as likely to have children as women without these difficulties (Vesga-Lopez et al., 2008). Research has looked at mental health conditions in parents and the impact this can have on their children. Field (1998) found that mothers who are depressed could be withdrawn or intrusive when interacting with their infants. It is suggested that this can have a negative impact on a child and mean that they are either understimulated or overaroused. However, it is discussed that these effects can be counteracted by other non-depressed caregivers and through intervention with both mother and child. A meta-analysis that looked at maternal depression and parenting behaviour found that mothers' irritability and hostility towards their children was consistently associated with depression, as was disengagement (Lovejoy, Graczyk, O'Hare & Neuman, 2000).

Mothers with a diagnosis of schizophrenia have also been the subject of a large body of research regarding mother-infant relationships. Infant-directed speech has been found to occur less often in mothers with

schizophrenia and reflects low maternal sensitivity (Wai Wan, Penketh, Salmon & Abel, 2008). Similar research with depressed mothers suggests that they too can use less infant-directed speech and that this is more negative than seen in healthy controls (Breznitz & Sherman, 1987; Herrera, Reissland & Shepherd, 2004). It has been suggested that low levels of infant-directed speech can lead to poorer learning and cognitive functioning in the infant (Kaplan, Bachorowski, Smoski & Hundenko, 2002).

There has been some research that looks into personality disorder and parenting, often with other co-morbid diagnoses due to the nature of the condition. Conroy, Marks, Schacht, Davies and Moran (2010) investigated maternal depression and personality disorder in relation to infant care. Participants had various diagnoses of personality disorder and the results were examined according to cluster of diagnosis. The results showed a significant detrimental effect on infant care practices in mothers with a cluster B personality disorder (borderline, antisocial, histrionic, and narcissistic) and depression.

The research discussed above suggests that there can be difficulties with parenting as a result of the parent having mental health difficulties. These difficulties are now described further below in relation to the clinical presentation of BPD and parent-child interaction studies within this diagnostic group.

1.8.1 Clinical presentation of BPD and parenting

The research outlined in the previous section would predict that mothers with a diagnosis of BPD are likely to have parenting difficulties. When adults become parents their style of caregiving is usually derived from their own internal working model of attachment (George & Solomon, 1996). As discussed, individuals with a diagnosis of BPD often have an insecure attachment style and have difficulties with relationships, which can lead to impulsive behaviour, such as self-harm. Mentalisation can also be problematic. There is also the potential risk of children of mothers with BPD having to be removed from their parents due to some or all of these difficulties, such as emotional dysregulation, self-harm, and suicidality (Chlebowski, 2013).

Crittenden and Newman (2010) looked at representations of attachment in mothers with BPD and a control group, using the Adult Attachment Interview (George, Kaplan & Main, 1985-1996). They also looked at other co-morbid conditions such as depression and eating disorders. They found that mothers with BPD showed extreme volatility of arousal and were more likely to have unresolved losses or traumas. The authors discussed this in the context of the DMM (Crittenden, 2008) and that increased unresolved trauma could mean mothers feel a need to protect themselves, and this may reduce their availability to care for their child (Fuertes, Faria, Soares & Crittenden, 2009). However, this study was limited by the small sample size and the fact that mothers were required to

talk about their traumas. Individuals with BPD may have experienced

trauma at a very young age and therefore may not be able to consciously

recall these events (Yen et al., 2002). Despite the possible limitations of

this study, a volatile parental response is likely to create anxiety and

potentially create an invalidating environment for a child. If a parent

struggles to regulate their own emotions they are likely to find it difficult to

behave in an emotionally validating way towards their child. Newman and

Stevenson's (2005) paper provides further evidence for this hypothesis as

they suggested that mothers with BPD may find it difficult to understand

and respond to their infants' emotions. They stated that mothers may

"misinterpret or avoid the infant's communications" (Newman &

Stevenson, 2005, p.387). Mothers with a diagnosis of BPD may invalidate

their children's emotions and may have difficulties with modelling

appropriate emotion regulation strategies due to their own difficulties with

emotional regulation (Paris, 1999; Stepp et al., 2012). In a further paper,

Newman and Stevenson (2008) suggested that mothers with a diagnosis of

BPD are likely to have difficulties with empathic parenting.

　　　As previously highlighted, women with a diagnosis of BPD are

likely to have experienced childhood trauma that is unresolved and it is

likely that this will impact on parenting. These traumas are likely to still be

present and can be replayed in the here and now (Wilkins & Warner, 2000).

Newman and Stevenson (2005) discussed that mothers with BPD may fear

repeating or can potentially re-enact these traumas with their children. The

parent may view the child as being part of this trauma by identifying them

with figures that enacted past abuse. This can cause difficulties within the

parent-child dynamic. Similarly, Lamont (2006) discussed that unresolved

trauma may impact on a mother's ability to be emotionally responsive to her

child due to the ongoing difficulties with recalling these traumatic

memories.

The fact that children are dependent on their parents may be difficult

for individuals with BPD. They may also struggle with feelings of rejection

from their child (Newman and Stevenson, 2005). The infant may be seen as

either a 'good' or 'bad' part of the self. Individuals with a diagnosis of BPD

can idealise or devalue their relationships with others (Lamont, 2006). This

would be problematic when parenting as this could potentially confuse a

child and be invalidating.

Individuals with BPD often have an unstable sense of self. As

infants develop their sense of self through interaction with their parents, it is

likely that this will have a negative impact on the child's own sense of self

(Lamont, 2006).

A recent systematic review looked at personality disorder and

parenting ability in terms of attachment theory (Laulik, Chou, Browne &

Allam, 2013). Conclusions from the review were that personality disorder is

a risk factor for parenting difficulties and impaired parent-child interaction.

However, the authors conclude that further research is needed within this

area to establish how this may be different depending on diagnosis and how

parenting changes over time.

A number of parent-child interaction studies have been carried out to investigate how mothers with BPD interact with their infants. These studies will be outlined in the next section.

1.8.2 BPD parent-child interaction studies

The current research regarding BPD and parent-child interaction was explored. Embase, PsycINFO and MEDline were searched using the following key terms and Boolean connectors:

1. "Borderline personality disorder" (Title and Abstract)

2. Parent* OR mother* (Title and Abstract)

3. Child* OR infant OR baby OR babies (Title and Abstract)

4. Search terms 1 AND 2 AND 3 (combined)

A manual search was also performed by examining the references of the relevant articles identified in the database search. Papers were included if they examined parent and child interaction in mothers with a diagnosis of BPD. Only English language papers were included. In total, seven articles were found that met this criteria. The key themes from these seven articles will now be discussed and evaluated below.

One type of parent-child communication that has been investigated is that of still-face interaction. This involves a parent maintaining eye contact with their child without showing any facial expression or response to the child's behaviour. Crandell et al. (2003) asked eight mothers with a

diagnosis of BPD and a control group of twelve mothers to undertake still-face interactions with their two month old infants, in order to investigate how the infants responded to an emotionally unreactive parent. They found that the children of the mothers with BPD appeared dazed and had lower affect following the still-face from their mother, in comparison with the control group (U=26.0; p<0.05). The authors suggested that this shows dysfunctional self-regulation in children of mothers who have BPD and that the mothers' relational styles were intrusively insensitive. The authors rated mothers as intrusively insensitive if they behaved in a negative way when interacting with their child both prior to and following the still-face task, such as by responding in a hostile or rejecting manor. Hobson et al. (2005) also used a still-face (set situation; Winnicott, 1941) interaction but with a stranger rather than the mother, using the Strange Situation (Ainsworth & Wittig, 1969). This study also examined intrusive sensitivity in mothers with BPD and their infants during semi-structured play. A control group with no diagnosis also took part. The results found that the infants of mothers with BPD were less 'available for positive engagement' when faced with a still face stranger and that they displayed a disorganised attachment towards their mothers. The mothers with BPD were again found to display more intrusive sensitivity than controls. Still-face research can be criticised, as the infant and mother are both placed in an artificial situation where they may perceive that professionals are evaluating them. As individuals with BPD report experiencing stigma from professionals they may feel anxious about how they appear to behave as a parent. Both parent and child may

potentially behave and respond differently to how they would in their usual environment.

Further research has examined child response to strangers and separation and reunion with the mother. Hobson et al. (2009) used the Strange Situation (Ainsworth & Wittig, 1969) to assess separation and reunion in mothers with BPD and their infants. They also used a control group with no diagnosis and a group with depression. They found that the infants whose mothers had a diagnosis of BPD showed frightened or disorientated behaviour and that the mothers showed disrupted affective communication. They concluded that BPD is associated with dysregulated mother-infant interaction.

Emotional recognition studies have also been used to investigate parent-child interaction in mothers with BPD. Elliott et al. (2013) asked mothers with a diagnosis of BPD to label emotional states in their own and unknown children by viewing images of infants' faces. Interestingly, this research showed that mothers with BPD found it more difficult to accurately identify neutral facial expressions and instead rated them as negative. There was no difference in ability to recognise emotions of known or unknown infants. Individuals with a diagnosis of BPD may innately view other people as a potential threat and this may be related to the experience of childhood trauma from an attachment figure. An alternative hypothesis that is suggested by the authors is that childhood trauma may contribute to impairment in reflective functioning in mothers with a diagnosis of BPD (Elliot et al., 2013).

White et al. (2011) investigated mother-infant interactions with mothers with BPD in comparison to other psychiatric diagnoses. The authors controlled for confounding variables in the analysis. This means that the results are likely to be more valid (Field & Hole, 2003). The authors reported that mothers with BPD or BPD and depression touched their infants less and engaged in less game playing than mothers with depression and healthy controls. Maternal imitation was the only impaired behaviour in BPD alone and the authors suggested that this could mean there is a specific subgroup within BPD. They also found that infants whose mothers have depression (with or without BPD) showed greater gaze aversion. Newman et al. (2007) also recruited mother infant-dyads of mothers with BPD and healthy controls, and assessed their interaction. They found that mothers with BPD were less sensitive in their interaction and were also less structured in their play. Infants of mothers with BPD were less responsive and the mothers reported feeling more incompetent and distressed in comparison to the control group.

Apter-Danon and Candilis-Huisman (2005) discussed that mothers with BPD interact intrusively with their infants and that this may due to responding to their own internal emotional cues rather than their child's. The authors stated that 'intensive therapeutic interventions' need to be implemented in order to improve mother and infant interaction.

These studies show that there can be some difficulties with parent-child interaction in mothers with BPD. It is therefore important to consider how these difficulties then impact on children.

1.8.3 Outcome research of children whose mothers have BPD

The research discussed previously suggests that children whose mothers have a diagnosis of BPD may be more likely to receive a diagnosis of BPD themselves. Other research also suggests that they may be more likely to have other significant difficulties. Children whose parents have a diagnosis of Personality Disorder have been shown to be more likely to develop mental health problems themselves (Berg-Nielsen & Wichstrom, 2012). Feldman et al. (1995) reported that children aged 4 – 18 whose mothers had BPD were more likely to have moved schools and been exposed to drug and alcohol abuse, than children of mothers with other personality disorders. A number of other studies have shown that children whose mothers have a diagnosis of BPD are more likely to be diagnosed with attention difficulties, delinquency, and aggression than children of 'healthy' controls (Weiss et al., 1996; Barnow, Spitzer, Grabe, Kessler & Freyberger, 2006).

It has been suggested that children of mothers who have a diagnosis BPD are more likely to have a disorganised attachment style (Main, 1995). Some researchers suggest that this is likely to impact on a child's cognitive development, and that children with an insecure attachment style typically have lower scores on the Stanford-Binet test (Crandell & Hobson, 1999).

Macfie and Swan (2009) compared children whose mothers had a diagnosis of BPD with a normative comparison group. They used story-stem completion to look at parent-child role reversal and emotional regulation. The results showed that the children of mothers with BPD were

more likely to show parent-child role reversal, fear of abandonment, incongruent representations of the self, and poorer emotional regulation in comparison with controls. Maternal depression was controlled for statistically. They found that these results were associated with maternal confusion of identity and self-harm.

1.9 Ideologies of motherhood

When considering the parenting experience for a mother with a diagnosis of BPD, it is important to first consider the dominant cultural ideologies of motherhood. In western societies, motherhood is often constructed as being synonymous with femininity (Choi, Henshaw, Baker & Tree, 2005). Feminist writers have commented on the unrealistic assumptions that are part of gendered discourse in society, for example, the 'good' mother is seen to be responsible for both the domestic chores and childcare. She is seen to cope well and manage both of these pressures in a calm and passive way (Graham, 1982; Nio Ong, 1985). The transition to motherhood has been found to be challenging for some women, perhaps due to this idealised narrative of the 'good mother'. Choi et al. (2005) found that mothers can compare themselves with this narrative and feel inadequate. The mothers in this study felt that they needed to hide their perceived inadequacies as they felt that these did not fit with how a mother 'should' be coping. The feelings that a mother has towards her child are assumed to be positive and both 'natural' and 'instinctive (Bobel, 2001).

The meaning of motherhood and development of identity as a mother can vary depending whether one wished to become a mother in the first place. Miller (2005) has discussed that becoming a mother involves a change in the sense of the self and how one wishes to present oneself socially.

These dominant ideologies may cause difficulties and a different experience of being a parent for mothers with a mental illness, including BPD.

1.10 – The experience of being a mother with a mental illness

It could be hypothesised that being a mother with a mental health diagnosis will offer different experiences to that of those without a mental health condition. When individuals are unwell, they are usually able to relinquish responsibilities until they recover but a mother is not usually able to do this (Davies & Allen, 2007). If a mother is forced to give up care for her children due to illness, this can lead to feelings of failure and may exacerbate any existing mental health problem. Having a mental illness is not viewed as being compatible with being a mother (Marshall, 1991). Tardy (2000) reported that women may idealise motherhood and as mental illness is not seen as being part of this ideal, mothers with a mental illness may view themselves as failures.

A recent systematic review by Dolman, Jones and Howard (2013) examined the qualitative literature regarding the experience of being a

mother with a serious mental illness. Twenty-three papers were included within the review. Participants within these studies had various mental health diagnoses, including schizophrenia, psychosis, bipolar disorder, and depression. Two overarching themes were identified from the 23 papers: experiences of motherhood and experiences of services. Stigma, guilt, fear of custody loss, concern over the impact of mental illness on the child (with sub themes of: genetic, environmental, and secondary stigma), isolation, coping with dual identities, and the centrality of motherhood, were the key themes found within the theme of experiences of motherhood. The two themes under the heading of experiences of services were: problems with service provision and positive experiences of services. The authors of the review conclude that these findings are relevant regardless of diagnosis or sociocultural context. Another interesting finding was that some participants reported that the stigma they experienced from both health professionals and society in general, was exacerbated by becoming a mother (Wilson & Crowe, 2009). In particular, dual roles were discussed within this in terms of being a woman who is mentally unwell and socially stigmatised, whilst simultaneously being a mother who is expected to fulfil a societal idealised role of motherhood (Davies & Allen, 2007). The review contained only one study that included a very small number of participants with a diagnosis of BPD. Therefore, it is unclear whether similar results would be found in mothers with this diagnosis. The majority of the 23 studies included participants with various diagnoses and did not differentiate between these diagnoses in the reporting of results. There could potentially be differing views on some aspects reported, depending on diagnosis.

1.11 The Experience of being a mother with BPD

1.11.1 Stigma

As has been discussed in the preceding text, individuals with a diagnosis of BPD are commonly subject to stigma due to their diagnosis. This stigma may be further compounded by the parenting role, as mothers with a mental illness have reported experiencing stigma. The literature that is available around BPD and parenting is predominately negative and often ignores the experience of the individual. This dominant negative narrative is evident in Lawson's (2000) discussion of the differences between the ideal mother and the 'borderline mother'. Lawson's views could be perceived as an overly negative view of a parent with BPD as it is highly unlikely all parents with BPD exhibit the behaviours discussed all of the time. It is also likely that mothers without BPD experience some of those feelings described as being related to BPD.

Similarly, Neuman (2012) also outlined parenting problems that are often experienced by parents with a diagnosis of BPD, taken from Mason and Kreger's (p. 178-181, 2010) book. They discuss the difficulties that individuals with BPD often experience. Although these themes may be relevant to the current study, they could be perceived as an overly negative or pathologising view of an individual with a diagnosis of BPD and their ability to parent. Neuman's (2012) paper also discusses the theoretical impact of BPD on parenting, particularly in relation to child custody and visitation. She outlines evidence that suggests BPD may be inherited and

how "borderline behaviours" may impact on a child. Treatment issues within BPD are also discussed in terms of long term prognosis and how this may impact on parenting ability. It is suggested that Lawson's (2000) 'Ideal mother vs. Borderline mother' criteria be used when evaluating an individual's ability to parent. This is an extreme way of evaluating parenting ability, as it is not recognised that it could be argued that the ideal parent does not exist. Statements are made within this paper, implying that all mothers with a diagnosis of BPD are the same, e.g. "Now is all that matters to people with BPD, and children are confused by how quickly anger is forgotten", p. 242, Neuman (2012). Some of these statements sound very pathologising and are made without any reference to research evidence, which questions the validity of some of the ideas suggested. The majority of evidence discussed in this article, regarding inability to parent appropriately, comes from American sources. Therefore, it may also not apply within other cultures or other societies may view this evidence differently.

1.11.2 Further experiences of BPD and parenting

The literature discussed in the previous section outlines professionals and academics perceptions of the experience of parenting with BPD. It seems that there are only a small number of relevant research papers within this area that specifically ask mothers with BPD about their experiences of parenting.

One research study (Newman et al., 2007) asked mothers about their perceptions of their parenting ability using questionnaires. The authors

noted that mothers with BPD perceived themselves as being less competent and that they often felt disappointed about their abilities. Mothers in this study also reported experiencing significant stress related to being a parent. A case study by Newman and Stevenson (2005) illustrated that the parent discussed reported feeling overwhelmed and feeling anger towards their child. This parent also described feeling that she was a bad mother and wondered if her daughter hated her. A further case study by Newman and Stevenson (2008) reported similar experiences in one mother who felt overwhelmed and saw herself as a bad parent. Stepp et al. (2012) and Chlebowski (2013) reported that mothers with BPD have discussed fearing their child growing up and no longer needing them anymore. These experiences make sense in the context of the clinical presentation of BPD and how this may impact on parenting. It would seem that parenting can be a distressing experience for mothers with BPD, due to a variety of reasons.

One qualitative study (Savvidou et al., 2003) looking at experiences of parenting included two mothers with a diagnosis of BPD. The authors used interviews to try and understand the discourse of parenthood and mental illness within this group of people. Unfortunately, the authors do not differentiate between diagnoses when reporting the results. However, the general findings of this study showed that all participants reported that they had found parenthood a 'great experience'. It was also reported that the women in this study felt stigmatised by society in terms of being a mother with mental illness. This literature is in contrast with the other experiences discussed above about mothers with BPD finding motherhood an overwhelming experience.

Overall, the voice and direct experience of mothers with this diagnosis are lost within the existing literature, apart from the few quotes and observations in the literature discussed above. It would seem that mothers with this diagnosis are subject to increased stigma and this is evident throughout the literature. It is interesting that in an area where the literature is so underdeveloped, there is a lack of research exploring the lived experience of parenting with a diagnosis of BPD and a relative lack of studies that might guide treatment and support interventions.

1.12 Rationale for current study and research question

The findings discussed above show that there is limited research that looks at the experience of being a mother with BPD. It seems that when experiences are investigated, this is only a very minor part of a research study or a single case is used. This means that the specific experience of being a mother with this diagnosis is lost or diluted within the current literature. As Dolman et al. (2013) demonstrate, there are a number of qualitative studies that investigate mental illness and parenthood, but these studies do not include mothers with a diagnosis of BPD. Therefore, it is unknown whether this particular group of people will have similar experiences of parenting to those of people with other mental health diagnoses. Savvidou et al.'s study suggests that they might but there are also likely to be differences based on the theoretical literature previously discussed. Stepp, Whalen, Pilkonsis, Hipwell and Levine (2012) recently published what they entitled a "call to action" stating that more research is

needed into parenting practices within BPD. They state that parenting practices are important when thinking about transmission of diagnosis, as evidenced in the research about outcomes of children whose mothers have BPD. It would be helpful to know more about the experience of parenting for mothers with BPD in order to help provide further support and appropriate interventions for this group.

This study therefore aimed to explore the experience of parenting in mothers with a diagnosis of BPD. A qualitative methodology was chosen in order to fully capture the depth, variation and detail of these individual experiences.

The primary research question within this study was: how do mothers with a diagnosis of BPD make sense of their experiences of being a parent?

Chapter 2: Method

2.1 Design

The current study utilised a qualitative methodology due to the limited research currently available regarding the experiences of parenting in mothers with a diagnosis of BPD. Qualitative research is invaluable in developing an understanding of individuals who are part of a particular group (Henwood & Pidgeon, 1992). Interpretative Phenomenological Analysis (IPA) (Smith, 1996; Smith & Osborn, 2003) was used to explore the experience of being a mother with BPD via individual interviews.

2.2. Interpretative Phenomenological Analysis

IPA is more than just a method of analysis; it is a stance and perspective that impacts on design of research, data collection, and analysis (Larkin, Watts & Clifton, 2006). This research used IPA founded on the principles outlined by Smith, (1996) and Smith & Osborn (2003). Smith, Flowers and Larkin (2009) describe IPA as a qualitative approach that focuses on exploring the way in which people make sense of significant life experiences. IPA aims to get as close to experience as possible but also recognises that how these experiences are interpreted is situated within a particular context for both the participant and the researcher. It draws on existing theoretical constructs and whilst it is predominately idiographic, it also looks at the shared as well as the individual experience within a particular group of people. IPA does not aim to predict or establish cause

and effect (Willig, 2001) but rather to understand personal meaning within context. IPA is based on a number of different theoretical and philosophical ideas. In order to understand the IPA approach it is important to have some understanding of these ideas and as such they will be presented in turn.

IPA is grounded within the phenomenological tradition. Phenomenology is intersubjective and is concerned with the study of being and human experience (Moran & Mooney, 2002). It was developed from the work of Husserl (1925). Husserl argued that the scientific tradition and the empirical approach do not acknowledge personal experience and perception. We are unable to see the world objectively, as quantitative methods suggest, as how we view things is dependent on our own views and experiences. Philosophers such as Heidegger and Sartre further developed Hurssel's work. They focused on the meaning of experience within the individual's context of living in the world and not in isolation. This is a more interpretative stance. Our attempts to understand others experiences are interpretative. For this reason, IPA draws on both phenomenology and hermeneutics.

Hermeneutics is the theory of interpretation (Smith et al., 2009). Heidegger's work looked at hermeneutic phenomenology and argued that phenomenology is intrinsically interpretative. We are unable to be objective as we are always engaged within the world ourselves. However, we are able to bracket off our own assumptions, but Heidegger argued that this can only ever be partially achieved. This requires awareness and reflection on our own experiences and assumptions. The hermeneutic circle s a key concept within IPA as it explains that understanding is cyclical. To understand any

part we need understand it as a whole and vice versa (Smith et al., 2009). This demonstrates the importance of context and that understanding and experience are not fixed as they change as we interact with the world around us. Thus the interpretation we have of something on one given day may be different on another day due to our evolving experiences that may lead us to revise our previous understanding. This is particularly important within IPA as our views of the data may change as we read other parts of the data. This demonstrates the importance of continually re-reading and commenting on the data.

IPA involves a double hermeneutic (Smith & Osborn, 2003). That is, the researcher is making sense of what the participant is saying whilst the participant is also making sense of their experience. It also involves a double hermeneutic in that the researcher is wanting to understand the participants experience and 'be in their shoes' but at the same time is also questioning and analysing what the participant is saying (Smith et al., 2009). This interpretative aspect is always grounded within what the participant has said. IPA uses both phenomenology and interpretation in that it attempts to understand the experience of a participant whilst recognising that this is interpretative for both participant and researcher. In a sense, we can never get to the pure experience. We can just attempt to get to it through interpretation.

IPA is idiographic by nature as it is concerned with the individual's experience. It can be used for a single case study (Smith, 2004) but it is also useful when looking at a small group of people's shared experience. It can give us information about the similarities, differences and patterns of

meaning that are present in the accounts of people that are reflecting on a shared experience.

Willig (2001) argues that a phenomenological approach can be used to explore any human experience. IPA has been extensively used in both health and clinical psychology, and with individuals with diagnoses such as psychosis or BPD (Horn, Johnstone & Brooke, 2007; Nehls, 1999; Newton, Larkin, Melhuish & Wykes, 2007). IPA has been used within these areas as it is able to capture the in depth experience of individuals who share a specific experience, often within groups that can be more difficult to access (Smith et al., 2009). It is able to do this in a highly detailed way and acknowledges the cyclical nature of interpretation. IPA was chosen for this study, as the aim was not to construct a theory but instead to explore and make sense of the experience of being a mother diagnosed with BPD. The researcher wanted to fully capture these experiences and understand these as closely as possible. As there is limited literature that specifically explores this, IPA was considered the most appropriate methodology as it is recommended for initial exploratory work. Given the likely complexity of these experiences, a qualitative approach was chosen as it allows more in-depth exploration of each person's individual experience, that quantitative measures would not be able to capture.

2.3 Participants

Participants were all mothers with a diagnosis of BPD currently receiving support from a specialist Personality Disorder service. Mothers

who had current child protection concerns or all of their children permanently removed into care were excluded from the study. This was due to ethical reasons as it could potentially be more distressing for participants to talk about these experiences. Mothers who had no biological children or who were not fluent in English were also excluded from this study.

Participants were aged between 38 and 53 years old, with a mean age of 46.6. All participants were white British. Two participants worked part time and the other three reported that they did not work currently. More detailed information about participants is included in chapter 3.2.

2.3.1 Sample size

IPA uses purposive sampling in order to gain an insight into a shared experience. Richness and depth of the data collected is more important than the number of participants included within a study (Smith et al., 2009). Five participants were interviewed with each participant being interviewed once. Smith et al. (2009) recommend a sample size of four to ten interviews for professional doctorates. The researcher had hoped to recruit between six to eight participants. However, there were a number of difficulties with recruitment, these are outlined and discussed in chapter 4.4.1.

The service approached initially took 20 research packs to give out to potential participants. These packs included a participant invitation (Appendix 1), Participant Information Sheet (Appendix 2), Consent to Contact form (Appendix 3), and an envelope to return this in. The service

handed out all of the research packs and five Consent to Contact forms were returned. There were some difficulties with being able to get in contact with potential participants via telephone. The researcher discussed the research project with participants and arranged to meet with five people for interviews, with support from the recruiting service around organising this. A number of participants did not attend the first arranged interview but informed the service that they would still like to take part in the study, therefore a further interview was arranged. One participant became unwell prior to taking part in the study. The recruiting service handed out a further five research packs and from this one more participant was recruited. Further demographic information for each participant is described within the results section.

2.4 Designing the Interview

The interview was semi-structured and designed to elicit experiences (e.g. what has parenting been like for you?) and the meaning attributed to these experiences (e.g. how do you make sense of this?) The interview schedule (Appendix F) was developed using guidance from Smith et al. (2009). The questions used were open and encouraged description and narrative. Some of the questions involved comparing and contrasting a particular experience whilst others were more evaluative. The interviewer often used prompts such as "Can you tell me more about that" in order to elicit further detail from the participant. The researcher practiced their interview technique with a person independent of the project, prior to interviewing participants. This was in order to ensure that the questions

were clear and made sense.

Interviews were planned to last approximately one hour. Interview times varied from between 34 to 87 minutes long, not including the time taken at the beginning to explain the study or the debrief following completion of the interview.

2.5 Ethical Considerations

Prior to the research commencing, ethical approval was sought from an NHS Research Ethics Committee (REC). Approval was also sought from the local NHS Research and Development (R&D) department in the Trust where participants were recruited from. A favourable ethical opinion and R&D approval were granted (see Appendix G). A substantial amendment was also submitted and approved (see Appendix G).

2.5.1 Consent

Clinicians within the specialist personality disorder identified potential participants and spoke to them about the study. This meant that participants were not placed under undue pressure to take part in the research, as the researcher was not approaching participants herself. Participants were informed that their involvement in the study was entirely voluntary and that they could decide to withdraw from the study at any time without giving a reason, and without this affecting their care. Written informed consent was taken prior to the interview commencing.

2.5.2 Confidentiality

It was explained to participants that the interview would be confidential but that if any current risk to themselves or others was disclosed then this information would need to be shared with the service. It was also discussed that complete confidentiality could not be guaranteed due to the use of direct quotes in the write up of the study. However, it was explained that all identifying information, such as names, would be changed.

Written consent for audio recording was obtained prior to the interview commencing. Participants were assigned unique participant identification numbers and all identifying information was anonymised during transcription. All information collected was stored securely in line with the Data Protection Act. The consent forms that contained personal data were stored separately in a locked file. Anonymised data was kept separately from this at all times and was stored securely on a password encrypted USB memory stick.

2.5.3 Patient distress

The researcher recognised that discussing experiences of motherhood could potentially be difficult for this client group, particularly due to the emotional difficulties that they may experience. Participants were only recruited from specialist services to ensure that they already had

intensive support in place. The interview was arranged to take place at the service at a time when there were clinicians or a drop in clinic available following the interview. This was so that participants could access support from the service following the interview if needed.

Participants were aware of what the research topic was and that they would be asked about their experience of being a mother. They were encouraged to only share what they felt comfortable with and reminded that they could stop the interview at any time or not answer a question. The interview schedule contained open questions that participants could choose to answer, as they deemed appropriate.

At the end of the interview, the participant and researcher had approximately ten minutes to reflect on the interview together. They were directed to utilise any existing support that they already had in place if needed. If a participant reported any distress following the interview, it was planned that the researcher would support the participant to discuss this with a staff member.

2.6 Procedure

The researcher attended a team meeting at a specialist personality disorder service, and explained the research to the team via a presentation. The team agreed to identify participants that met the inclusion criteria to give the research packs to. The researcher left a drop box in reception for participants to return their forms in. The researcher then regularly liaised

with the service to check how recruitment was progressing and to collect Consent to Contact forms.

The researcher contacted potential participants that had completed the form and explained the research further and answered any questions. If the participant stated that they were interested in taking part, a convenient interview time was arranged, on a day where a drop in clinic was available. The interviews all took place at the service base.

At the interview, the researcher introduced herself and thanked the participant for attending. With the participants consent, the researcher turned the audio recorder on immediately, and explained that this was so that they could acclimatise to the presence of the audio recorder. The researcher then checked that the participant was familiar with the Participant Information Sheet and gave a verbal outline of the study. The researcher explained the importance of the participant only sharing things that felt comfortable to discuss. The researcher also explained that the participant could end the interview at any time and that they could withdraw from the study at any time, up until the research had been submitted to the University. Confidentiality and the limits to this were explained, as was anonymity in the write up. It was discussed that the interview would last for up to approximately one hour with a further ten minutes for debriefing at the end. The researcher explained that there were no right or wrong answers to the questions asked. The researcher also said that no assessment of parenting was being made in any way and that the research was genuinely interested in the individual and their experiences. In order to help the participant feel more comfortable and familiar with the style of

interviewing, the researcher explained that the interview might feel like a one sided conversation and that some questions may be repetitive or seem obvious. This was explained in the context of the researcher wanting to fully understand the individual's experience. The researcher asked whether the participant had any questions. Prior to the interview starting, the researcher asked the participant to read and sign a Consent form and complete the Demographics form (Appendix E). The researcher then reminded the participant to take their time in thinking and answering the questions, and checked that they were happy for the interview to begin.

The researcher used a semi-structured interview technique in that an interview schedule was prepared with some prompts but the interview progressed according to what the participant discussed. At the end of the interview, the researcher thanked the participant for sharing their experiences and taking part. The researcher and participant then had ten minutes to debrief and reflect on the interview together. The researcher asked how the participant was feeling and reminded them to utilise any existing support that they already had in place, if needed. The researcher asked the participant whether they would like to access the drop in clinic that was available that day, and arranged this if appropriate. Participants were then given a contribution towards their travel expenses and asked to sign a receipt to say that they had received this. The researcher discussed sending the participant a summary of the results if they had indicated that they would like this on the Consent form. Participants were thanked for their time again and the interview was then complete.

2.7 Data Analysis

The researcher transcribed each interview verbatim. The transcripts were then analysed using the procedure for analysis set out by Smith et al. (2009). This involves studying the data both individually and as a shared set of experiences, moving between the phenomenological and the interpretative. The researcher started to analyse the data whilst recruitment was still ongoing to allow for familiarisation and immersion within the data. The process of analysis will now be outlined in detail.

The researcher initially read and re-read each transcript and made comments and reflections on what was immediately noticed within the data. Smith (2007) terms this 'open coding', this step allows the researcher to start to bracket off their own preconceptions. Descriptive comments were then made in order for the researcher to attempt to identify what each participants particular experience was, what this meant to them, and how they felt about it, based on what was explicitly said within the interview. This process involves identifying the phenomenological aspects of the data. The researcher then went on to make interpretative linguistic and conceptual comments regarding the participants account. This involved asking questions of the data such as, what does that tell us that the participant used a particular metaphor to describe this, and what does this mean for this person in this context? Smith (1996) states that this process involves making "cautious inferences about discursive, affective and cognitive phenomena". Appendix H includes an example of a coded transcript.

Following the process of coding, the researcher started to identify and develop the emerging themes by noting them in the left hand column of the transcript. Commonalities within the emergent themes were then examined and grouped accordingly in order to start developing subordinate themes. The researcher wrote a descriptive narrative of each theme, evidenced from the data, and direct quotes were identified to evidence each theme (Appendix G). The researcher then looked at all the transcripts together to identify patterns and differences across the data. Superordinate themes were then developed from the clusters of subordinate themes.

Throughout this process, the researcher's supervisor and another member of the research team who is experienced in IPA research reviewed the transcripts and themes. Discussions were had with members of the research team regarding the process of analysis. The researcher kept a log of the decisions made and extracts of the analysis can be seen in Appendix G. The researcher also kept a reflective diary during the research process, where reflections about the process of analysis were made.

Chapter 3: Results

3.1 Overview

This chapter begins by outlining further demographic information about each participant in order to provide the reader with the context in which the participant's responses occur. The chapter then goes on to discuss each identified superordinate theme in detail and the subordinate themes related to each superordinate theme. Commonalities and differences within the data are outlined. Some observations about the interviews are included, taken from the researcher's reflective diary.

3.2 Information about participants

Table 1 provides further information about each participant's children, as taken from the Demographics Questionnaire. Detailed information has not been provided in order to protect anonymity.

Table 1: Information about participants' children

Participant	Number of children	Gender of children	Approximate age range of children	Any children living at home?
A	2	Male	20s	Yes, both
B	3	2 Female, 1 Male	1 Teenager, 2 in their 20s	Yes, 2
C	2	2 Female	1 Teenager, 1 early 20s	Yes, 1
D	4	3 Male, 1 Female	3 in their 20s, 1 Teenager	Yes, 1
E	1	1 Male	Under 10	Yes

Participant E was the only participant to have a young child. Participant C identified on the questionnaire that her first-born child had died at the age of two. Participant D also disclosed during her interview that she had had a child that had died at a young age. Both participants B and E disclosed that they had experienced miscarriages. An observation recorded in the researcher's reflective diary was that both participants C and D seemed to find the interview more difficult emotionally than the other participants. They both were softly spoken throughout and looked upset at times. They also both requested that the interview end. Participant B appeared to be

happy throughout the interview and was frank in her manner of answering the questions.

3.3 Themes Identified

Three superordinate themes were identified that were common to most participants. These contained seven subordinate themes describing the participants' experiences of being a mother with a diagnosis of BPD. Table 2 summarises these themes.

Table 2: Identified superordinate and subordinate themes

Superordinate Theme	Subordinate Theme
1. Being a bad mother	a. Feeling undeserving b. Not feeling or behaving as a mother should c. Protecting child from the damaging self
2. Needing to be understood and accepted by children	a. The importance of children being supportive b. Dilemmas around disclosure
3. Lack of support	a. People on the outside don't always understand b. Being viewed as a diagnosis not as an individual

3.4. Theme 1: Being a bad mother

All participants talked about how they viewed themselves as a mother. The majority of participants made reference to evaluating their parenting ability and questioned whether they have been bad parents, as illustrated by participant C:

Interviewer: How do you think you would describe yourself as a parent?

Participant C: [..] pretty crap [laughs quietly][1] […] although they are where they are um [.......] yeah not [.....] can see one side of me saying you must have been good enough to [.] get them where they are but there's another big part of me that's critical and judgemental [..] of myself […] things could've been better [……….] suppose generally just see myself as being a bad mother

(Participant C, p.6, section 10)

Participant C views herself as being a bad parent and compares herself to her perception of a good mother:

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[1] Information written in [] indicates a non-verbal response by the participant or can also show where identifying information has been removed

. …maybe a good mother who could cope with getting up at the end

of the day would um [..] would go and do her tea maybe a good

mother would do this that and the other

(Participant C, p.13, section 18)

Being a good mother is important to participant C and she is self critical of

the decisions that she makes, believing that she is being a bad mother.

Parenting is viewed as either good or bad. This is not flexible, on a

continuum, or subjective.

A number of other participants shared similar views about their own

parenting and justified these conclusions in a variety of ways that will now

be outlined in the subordinate themes below.

3.4.1 Theme 1a: Feeling undeserving

Three participants described feeling undeserving of their children.

Participant E described fearing something bad happening to her son because

she feels she's a bad person:

…I don't think I'm a very good person I'm I don't think I'm very I

don't think I deserve the things that I have [.] and I kind of think that

I don't deserve him and that [..] there's going to be a price one day

that he's going be taken away from me [.] because I don't see how I

could've been given something so wonderful

(Participant E, p.20, section 36)

Participant E idealises her child whilst condemning herself. She feels

undeserving of happiness. Participant C shared a similar experience of

waiting for things to go wrong as she feels undeserving of good things:

…I don't do positive [laughs] for every good thing that happens

they'll be a ton of bad things that could happen and [.] constantly

waiting for everything to fall to pieces

(Participant C, p.7, section 11)

Participant D also reported that she has felt undeserving of her children:

…It's like [.] I never planned to become a mother [.] I didn't think it

was [.] it was for me [.] things like that don't didn't happen to me

(Participant D, p.13,

section 32)

These participants all share a similar experience of feeling

undeserving and a sense of waiting to be punished.

56

3.4.2 Theme 1b: Not feeling or behaving as a mother should

For some participants, there was a sense of feeling overwhelmed by motherhood and that this led to behaving and feeling in ways that participants deemed to not be 'motherly'. Participant D discussed how she struggles with her children's dependency on her, particularly if she feels she is unable to help them, as illustrated in the two quotes below:

Participant D:… I'm the first port of call if anything goes wrong [.] or if they want me to help them out with something the phone's going constantly […]

Interviewer: What's that like for you?

Participant D: That's hard [.] that's hard because a lot of the time I [.] there's nothing I can do and it's [.] it's tiring [..] it stresses me out yeah

(Participant D, p.11, section 28-29)

…it's changed now, now they do they're never off the phone now it's stupid things [.] I mean it's things that and I feel hopeless and helpless 'cos it's something I probably can't deal with

(Participant D, p.15, section 38)

Dependency is emotionally draining for Participant D and quite frustrating at times because she feels helpless. Mothers are expected to cope with dependency and to know what to do in every situation to support their child. Participant D is critical of herself because she does not know how to or feel able to meet this perceived responsibility.

Participant D also described how she had to try and feel a particular way towards her children and how this impacted on her:

It was emotionally draining trying to [.] umm [.] feel normal I suppose feel as your supposed to feel for them you know they'd sort of [.] aggravate me quite a lot and [.] yeah it was hard [..]

(Participant D, p.4, section 7)

Participant D feels that she did not naturally have the mothering instinct, this is illustrated in her use of language to say that she did not feel 'normal', as a mother 'should'. Her own expectations of what a mother should feel like were not met. This is illustrated further in the following extract:

It's just that you know if ever they hurt themselves [.] I was very hard […] I mean I see mothers now like in the street and think and all cuddling them and doing stuff like that with them and I never

used to do stuff like that with them I used to just [.] take their

attention away and say oh well you're going to be alright an [.]

because I just couldn't [.] handle it myself [..] yeah it was really

difficult [..] yeah it was really difficult [..] feeling guilty because [.]

because I knew I wasn't right and I shouldn't be like I was

(Participant D, p.4, section 10)

Participant D blames herself for not being able to do what she feels a

good mother should do. She feels unable to comfort her children as she has

seen other mothers do and feels ashamed that she is not behaving as she

believes a good parent should.

Participant B also described experiencing difficult feelings in

relation to one of her children:

If I could get away with leavin' him on the side of the road I

probably would've done (laughs) if it was legal 'cos he cried so

much

(Participant B, p.11, section 17)

Participant B laughs at saying this indicating that she is joking.

However, she wants to express and demonstrate how difficult and

frustrating being a parent can be at times. She also shares these feelings of

not feeling as a mother should. Participant C shared that she has experienced extreme emotions in relation to her children also:

> Grace* is very um [..] feisty I think that's quite the right word […] so we struggle when we do have times when we sit and talk [..] um but she's all always very um [….] think of the right word she's very judgemental she criticises every single part of my life [..] and she's very dominant [….] she's my daughter but [whispers] I hate her
>
> (Participant C, p.2, section 4)

Participant C seems to experience a strong emotional response in relation to feeling criticised by her daughter. She whispers that she hates her daughter indicating a sense of shame that she has these feelings towards her child. This shame is again related to not feeling as a mother should and is a shared experience amongst participants.

A further shared experience amongst participants was fear related to their children missing out on certain things growing up due to their parenting:

> …they didn't have [.] childhood like other family childhoods they didn't go to places I didn't take them out I didn't go to parties I

didn't do anything [.] and they've missed out [….] they missed out when they were little

Participant D feels that she should have been able to take her children out and do things with them and that her children have been deprived because of this. It seems she has generalised this to feeling like she did not do anything with them at all. Again, she has made sense of her experiences as not being 'typical' behaviour for a mother. She believes that mothers are expected to take their children out and to parties and that not doing this is a criticism of her parenting. Participant A talked about feeling that she had spoilt her children's younger years, as they had to grow up quickly:

I hope that whatever's happened in the past and the future that they can cope with [.] but it's always in the back of your mind that um you've spoilt their growing up [.] through sometimes being in hospital for long periods at a time

I just think they took on a lot [.] (clears throat) when they were younger than what they should've done

Participant A feels that her sons' childhood was impacted by her behaviour. There is a sense that participant A feels her children lost their innocence quickly and that they had to act older than their years. Participant A believes that her children shouldn't have had to grow up quickly and that a mother should not put her children in this position. She blames herself for this; this is evident in the language that she uses stating that she has 'spoilt' their growing up. Participant C discussed the lack of stability that she feels her children experienced due to her mental health problems:

…I mean they had no stability at all [..] they didn't know what they were going to come home to whether they were going to come home to me in bed or [..] come home to [.] tea on the table [.....] being in the hospital

Participant C is using a stark contrast here of 'normal' family life compared to being in hospital due to mental health difficulties. She is evidencing the instability of the family environment and her ability to parent.

Participant E talked about how some of her son's behaviours seem to have developed as a result of her difficulties:

Participant E: I think he always tries to please people and his friends and me and teachers he's always trying to please people [.] and it it saddens me that he's like that because he doesn't have to [.] try and please people sometimes you have to try and please yourself don't you

Interviewer: What's your understanding of why he does that?

Participant E: I think because he knows how ill I've been in the past [.] some of the things he's seen although he was like very young when it all happened he still remembers things

(Participant E, p.30, sections 55-56)

Participant E implies that she believes her son tries to please people as he fears that if he doesn't, he will upset them. Participant E feels that her son behaves like this due to her own behaviour and she experiences guilt about this.

Participant A also further discussed how her behaviour impacted on her children in terms of illustrating how she felt her behaviour was different to that of other mothers:

I'd promised that [.] er I'd try not to go back into hospital so that they wasn't on their own

This was difficult for participant A she feels guilty about going into hospital and not being with her children, as evidenced by making promises to her children that she would not leave them on their own. She indicates that she would like to be able to have some control over whether she is unwell or not as she says that she will 'try not to' go back into hospital. Participant A believes that mothers should always be with their children and that it is not usual for mothers and children to be apart.

Participant D also reflected on her mood swings and described feeling like she has failed as a parent because of this:

Interviewer: What was that like for you [.] having the mood swings and being a parent?

Participant D: Yeah that was difficult because one minute I'd say I would [.] I'd be fine and within the next minute I was either jumping down their throat or crying me eyes out it's [.] very difficult it's difficult [.] to live with [.] and as I say it's different for the people around because they don't know [.] what to say [.] what they say to you, you take totally the wrong way [.] half the time [..] you just feel like you're just a big failure

(Participant D, p. 14, section 36)

64

Participant D blames herself for her mood and the impact this has on her family. She feels that her mood swings are not part viewed as acceptable in mothers and that she is a burden on the family and has failed as a mother.

3.4.3 Theme 1c: Protecting child from the damaging self

Participants described experiences related to needing to protect their child from themselves. Participant C discussed how her behaviour nearly led to the removal of her children as they needed to be protected from her:

I wasn't always there for them [.] when I should've been [……..] there were a couple of times where [..] they were near they were nearly taken into social services [..] because my behaviour wasn't [.] good enough

(Participant C, p.14, section 19)

A number of participants described strong negative emotional reactions towards their children. Participant D described feeling that she had to distance herself both physically and emotionally in order to protect both herself and her children:

I just [..] would do so much and then wanted space [….] I just used to shut myself away in the bathroom [..] if they were arguing I'd just

shut myself in the bathroom and let them get on with it [..] I didn't

want to lose my temper with them

Participant D evaluates her behaviour as potentially being

dangerous. She views losing her temper as being a negative way to behave

towards her children and to protect them from this, and essentially from her,

she physically distances herself from them. Cutting off emotionally is a way

that participant D protects her children from her difficulties that she

perceives as being damaging, as illustrated in the following quote:

…I knew what I'd got to do and I done it but without any feeling it

was just like [.] you'd got to get up and get on with it and [.] it was

all done like robotic if you think [.] you know I kept them all I didn't

lose any of them so

Interviewer: Can you tell me a bit more about it being robotic?

Participant D: Well yeah it's just like being mechanical really doing

the things I'd got to do but with no extra because it was just too

difficult

There is a sense that her behaviour and emotions in general are unsafe and that she is only able to tolerate her own and her children's emotions for a limited amount of time before it becomes overwhelming for her. She also wants to protect her children from her own uncontained emotions and cutting off emotionally is the way that she protects them. Interestingly, she attributes being able to retain custody of her children due to this protection of cutting off emotionally. Participant B also described feeling cut off but she views this as being something that needed to be 'fixed' rather than as being a helpful way to protect her children:

I don't how to describe it it's just weird because I was numb [..] I just got on with what I was told to do [..] I didn't know where to go for help [.] I knew there was something not right but I didn't know what [..] I don't know [..] yeah that particular phase I do find it difficult to describe [.] I just made all the moves

(Participant B, p.6, section 10)

This experience seems to be in contrast with participant D's experience. Participant D viewed cutting off emotionally to be a way of coping and a way of keeping her children safe. Participant B viewed it as being part of mental illness and life events, and not a way of coping.

All five participants talked about the perceived impact that having a diagnosis of BPD had on their children. Two participants talked about this

67

in terms of questioning whether their own difficulties had 'damaged' their children in some way. Participant D described that she fears that her children worrying about her and not talking to her about their problems led them to have their own difficulties:

Well I feel like I failed the kids for a start [..] because they've all got problems they [.] they say they probably would've had them but [.] when they've come [.] living with me and they've turned to drugs and [..] it's my fault [..] people do say that [.] it's not necessarily down to me but I take it as a direct down to me [.] I don't believe them [..] if I'd have been more [.] with them more emotionally involved with them perhaps [.] they could've come to me and they would never had gone down those paths [….] they didn't talk to me as they were growing up they do now but they didn't then

(Participant D, p. 14, section 37)

Participant D feels that her children have their own difficulties as a result of her parenting behaviours. Earlier on in the interview, participant D discussed how hiding her emotions from her children was her way of protecting them. However, it seems that she feels that doing this has resulted in her children feeling unable to talk to her. Participant D may feel that her children felt unable to talk to her because they were concerned about her own difficulties. She blames herself that they did not talk to her, as she

believes that if they had, her children would not have used drugs. This indicates that participant D believes that if she had protected her children from her own difficulties, they would not have gone on to have their own problems.

Participant C talked about her daughter's behaviour and whether her own difficulties had led her daughter to behave in a certain way:

Interviewer: Could you tell me a bit more about that when you say finding it difficult to differentiate between, between, yeah normal teenage behaviour?

Participant C: yeah […......] yeah I suppose it's sort of hard to take a back step [.] with an open mind [..] um […] but it is difficult to know which side to be on [..] and perhaps you know Grace* passing her test driving going to college and [.] I want the car so I can go out tonight [.] maybe that's the normal bit of it [.] but the extreme of it is that [..] she needs the car for college and that's more important than me [..] and she's putting me down [….] which I don't think she's [..] I don't think she knows how much that affects me [.] by saying that you know her going to college and her going out and the car and [.] how much you spend on driving lessons [….] yeah part of me's really pleased for her that she can get out and [..] gives me a break when she's out as well [laughs] um [….] so yeah there there is [..] extremes of it is probably the [..] BPD

In this extract, participant C is discussing her daughter's behaviour and how she feels that the extremity of it may be related to her own diagnosis of BPD. Earlier on in the interview she talked about questioning whether her daughter's behaviour was 'normal' teenage behaviour and how it could be extreme. She reflects here on how her daughter's behaviour impacts on her and how it makes her feel about herself. She recognises some of her daughter's behaviour as being similar to her own and feels that she should have protected her daughter from this.

3.5. Theme 2: Needing to be understood and accepted by children

Four participants talked about their relationships with their children and the impact that this had on them in terms of needing support from their child and dilemmas about how much information to share with them about their mental illness.

3.5.1 Theme 2a: The importance of being understood

Two participants discussed that their children are a support to them. Participant A discussed how her sons support her with her mental health difficulties by attending meetings:

…um [..] they come to [.] different meetings with me when I [.] have a big meeting once every 6 months [.] so they can keep an eye on [.] on what to look for if I kind of like go through a bad stage

Participant A receives support from her sons in terms of them monitoring her mental health and they have taken on an element of the parental role with the participant becoming more like the child. This is also evidenced in the language used where she says 'big meeting' rather than naming it a review meeting. Being understood by her children is important to Participant A in terms of staying mentally well. Participant A also discussed needing support from her children when she returns from a hospital admission:

I knew that they [.] wasn't panicking about going, me going into hospital um [.] they knew that I was there to get better [.] and that I'd need support when I come out [.] um so them knowing a little bit about it [.] made me feel a little bit um better [.] about leaving them although it was never easy

This indicates a parent-child role reversal in terms of the children being needed to support their mother rather than vice versa. Participant A switches between the parental and child role in this extract as she discusses how she reassures and supports her children, as a mother, when she is admitted into hospital but then says about needing support from them herself. She also discussed that her children knowing about her difficulties made her feel a bit better as well as it helping her children. Telling her children about her difficulties allows her to feel supported and understood. Participant E also talked about how her son is a support to her:

…I just feel that when he's with me I can do things when I'm on my own I don't like doing things or when I'm with other adults I don't really like doing things [.] but when I'm with him I feel like I can do a lot more [.] it gives me a lot more confidence [.] I don't know why [..] just gives me like a strength

(Participant E, p.19, section 33)

There are also elements of role reversal here in terms of a child supporting its mother. Participant E also discussed further positives of being a mother in terms of the support and love provided by her child:

Interviewer: Yeah [.] ok [.] um what for you has been the best part of being a parent do you think?

Participant E: Um [.] the love that he gives me [.] knowing that [.] doesn't matter what I look like or [.] anything like that that he still loves me [.] y'know he's he's mine [.] he's I created him and and he's mine [.]

(Participant E, p.19, section 33)

Receiving unconditional love from her son is important to participant E. This is a need that she has herself, to be loved and accepted regardless of her appearance. The language she uses, saying that her child is hers, implies that she feels a sense of ownership over her son that perhaps reassures her that her son will not be able to leave her. She feels that her son accepts and loves her no matter what and this is important to her.

Participant C also discussed how she feels supported by one of her daughters:

Um but Sarah's*[2] very understanding with mental health and um [..] Grace isn't they are very different um [..] physically and personality

(Participant C, p.2, section 4)

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[2] * indicates identifying information has been changed

Needing to be understood in terms of how mental health difficulties impact on you is important for participant C. She feels contained and supported by this. This is evidenced further on in the interview when participant C discussed her daughter's differing reactions to disliking her self-harm:

Interviewer: How did you know that they hated it?

Participant C: […] Um [..] Grace* would keep a physical distance away from me [………..] Grace would tell me it's disgusting and um [……] and I think with Sarah she just saw that as a [.] trigger for me going down hill and again and [..] that's what she hated

(Participant C, p.19, section 26)

It is implied here that one daughter is more supportive and concerned whilst the other daughter sees her behaviour as contemptible. Participant C feels more supported and emotionally contained by how Sarah responds. There is an element of role reversal here also with participant C feeling supported and understood by her daughter.

Participant C also discussed how difficult it can be when she does not feel supported or accepted by her other daughter, as illustrated in the quotes below:

Interviewer: So what's that like for you with Grace?*

Participant C : Very difficult it really is she just knows [sighs] [...] I spose I spend most of my time trying the positive things to make myself feel better [..] and she'll just bring me straight back down

(Participant C, p.2, section 5)

Interviewer: how about your older daughter?

Participant C: We're really close yeah [.....] yeah it's lovely being with her [.....] yeah she's been wonderful had to grow up very quickly I think

(Participant C, p.3, section 7)

Participant C views her younger child as being more difficult and there is the implication that her younger daughter may deliberately behave in an upsetting manor. In contrast, the older daughter is described as being more pleasant to be with and that she has perhaps had to cope with a lot. Participant C is illustrating how difficult she finds it when her daughter is not accepting or understanding of her, and she relates this to compounding her mental health difficulties.

Participant E discussed how it helps her when her son instinctively knows how she is feeling and is able to support her:

Um as soon as I've made the decision that he's not going to school the relief is just like [.] it's overwhelming it's [.] you know it's like [.] god you know [.] and then I'll just say to Stephen* like [.] you alright babe and he'll go because oh you know they always try and he knows when I'm in that kind of mood he goes [.] (speaks quietly) I've got bit of a headache actually and I'm like are you have you and he's like yeah and I'll say do you think you should go to school and he'll I don't really think I should go mummy not today and I'm like ok then

(Participant E, p.15, section 26)

Here participant E is discussing how her son can tell if she does not feel happy for him to go into school as she is feeling anxious. She implies that he would try and miss school anyway when she says, "oh you know they always try", however it seems that what she is saying is that her son will sometimes miss school as he is worried about how it will affect her if he does not. This extract further illustrates how participant E feels supported and understood by her child and that this is important to her.

3.5.2 Theme 2b: Dilemmas around disclosure

A number of participants discussed about how much to tell their children about their difficulties. Some participants felt that honesty and truthfulness were very important whereas other participants wanted to keep

their difficulties hidden, both from their children and other people. A number of participants expressed concern around how disclosure would impact on their children whilst others worried about how it would impact on how other people treated their children.

Participant A discussed that she feels being open and honest with her children about her mental health difficulties is important:

…it was good to be able to kind of like keep them informed on the truth on what was happening throughout when they were growing up [.] because it's difficult for children to and other people to jump to conclusions on why you're in a [.] mental hospital

(Participant A, p. 1, section 1)

Participant A felt that it was important that her children knew why she was away from them in hospital. She didn't want her children or other people to view her as society stereotypically views people with mental illness. She is concerned about how the stigma that people with mental health problems experiences, indicated by her comment about how people jump to conclusions. Participant A discussed that she feels telling her children the truth has been key in ensuring her children's own wellbeing:

…you just put it in basic terms on you know [.] what was happening [.] um and then they weren't so scared about it

(Participant A, p.3, section 2)

I can't really say what it's like [.] for normal people to bring their children up [.] um that's all I can say is that [.] the boys have turned out ok […] but that's because they've known the truth [.] all the way through

(Participant A, p.18, section 27)

Participant A views disclosure as necessary and she feels that if her children had not known the truth about her difficulties that this would have been scary for them and perhaps they would have gone on to have their own difficulties. It is important for Participant A to be understood by her children and she attributes this understanding to be due to disclosure and sharing of experience. Participant A also talked about sharing her past experiences with her children and her concerns around how this would affect them:

…how they [.] reacted to [..] what they'd learnt in the past [..] um [.] James* James could be quite angry he's the youngest one [.] about [.] what happened to me [.] um […] and it was difficult um to how

James would react [.....] I didn't want something happening to them [.] because of what had happened to me

(Participant A, p. 22, section 37)

Participant A fears whether harm will come to her children as a result of disclosing her own experiences. There is a dilemma here for her about whether she did the right thing in disclosing these:

…it does make you wonder sometimes whether [.] you did the right thing by actually telling them [..] but you've always got that feeling that if you hadn't have told them [.] somebody else might have done

(Participant A, p.23, section 38)

Participant A feels that she was forced to disclose her experiences to her children as she feared that if someone else had told them then they would have been upset about this and maybe would have treated her differently. There is the implication that her relationship with her children may have suffered if she had not told her children herself and that other people may have not told them the truth.

Participant D felt that she should not let her children know about her difficulties, as she feared the impact this would have on them:

Participant D: I didn't want them to see [.] didn't want them to see it
[....]

Interviewer: Can you tell me a bit more about that?

Participant D: [..] I felt that I'd damage them [.] I didn't want to emotionally damage them [.] so if they didn't see me like that [.] it wouldn't worry them

(Participant D, p.6, sections 13-14)

Participant D believes that disclosure of her difficulties could damage her children in some way. This links with the earlier theme around needing to protect children from the damaging self where it was discussed that participant D does not allow her children to see her emotions as she fears that she, and they, would not be able to contain them. Disclosure of difficulties here is seen as damaging in contrast to participant A who felt that disclosure was important for her children's wellbeing. Participant D also discussed that now her children are older, she still does not disclose her feelings to them:

They still now don't know I still don't [.] don't show them any of my emotions at all [.] they've never seen me I [.] if they want to see me now and I'm not in a good place then [.] I'm there's some excuse that they can't come round [.] they don't [.] they don't see me like

that [..] because of the same reasons just to protect them [.] I don't

want people to worry about me either so [.] I don't want them to

Participant D believes that disclosure to her children about her difficulties will mean that they worry about her and that this would be a negative thing. She fears damaging her children or burdening them in some way if they knew how she was feeling. Participant C also discussed not disclosing her difficulties to her children:

…the self harm when the children were younger [..] it used to be oh yes the rabbit scratched me [laughs] oh yes the cat scratched me and um [..] but there wasn't any clear point I don't think when they realised that I was doing it to myself [.....] but they hated it

Despite not disclosing her difficulties, participant C implies that her children were aware of what was happening. It was difficult for her to tell them about her self harm as she feared their reaction, although she recognises that despite not being told explicitly, they were aware and hated that she was doing this to herself. Participant E discussed how her son is aware of her difficulties and the impact this has on him:

…he knows how ill I've been in the past [.] some of the things he's seen although he was like very young when it all happened he still remembers things [..] I think […] and he sort of I told him in basic terms that mummy's got a poorly head and sometimes mummy's grumpy and it's not your fault because mummy's head's poorly [.] and then sometimes he does say to me would your head be poorly if I wasn't here [.] and I was like well yeah it would be even more poorly because you're not here [.] you know and I tried to explain to him it's not his fault in any way shape or form

(Participant E, p.30, section 56)

Participant E has concerns around how her son knowing about her difficulties has impacted on him. She thinks that her son blames himself for her mental health problems. Choosing whether to disclose or not was not a decision for participant E, as she believes that her son remembers some of his earlier experiences of his mother being unwell.

3.6 Theme 3: Lack of support

The majority of participants made reference to the wider system around them as a mother and how they were or were not supported by other people, such as family and professionals

3.6.1 Theme 3a: People on the outside don't always understand

Participant A talked about people outside of her close family not understanding mental illness:

…when you're given a label [.] um [.] but people [.] on the outside don't really understand what that label means [.] um or what's going on in your head

(Participant A, p.7, section 8)

She refers to people on the outside not understanding what the label of BPD means and that this can cause problems. Participant B described predominately negative experiences in relation to the impact people outside of the family had on family life:

Interviewer: And when you went to ask for help with your younger daughter [..] I think you said you experienced prejudice then too [.] is that right?

Participant B: Yeah [.] Of course me mental health at the time was fine [.] but then because then they started [.] accusing suggesting and god knows what else and pressing buttons [.] my mental health then deteriorated

(Participant B, p.22, section 31)

I've always known leave me alone and I'm fine [.] professionals get

involved and start trying to use the kids against me basically [.] then

my mental health will deteriorate

(Participant B, p.40, section 48)

Participant B describes here how she felt that other people

questioning her parenting abilities led her mental health difficulties to

deteriorate.

Participant A spoke about how her early experiences have led her to

feel responsible for protecting her own children from the same experiences:

Interviewer: So I think you said that your experiences when you

were younger [.] meant that you were [.] I think you said protective?

Participant A: Yeah very [.] probably overprotective but [.] erm [..]

that's the way um [..] way it was really um it was the only way I

could [.] see about the boys being safe [.] um and that meant um

them not seeing certain people

(Participant A, p.8, section 9)

She feels that she needs to protect her children from other people as

they are likely to be dangerous.

Participant B discussed how other people perceive that she is meeting her own needs through her child:

…my son was covered in a rash one day [.] he was about 3 [.] and I took him to the G.P. [.] and the G.P. sat there and goes no what are you here really for [.] my son has a rash all over him look [.] head to toe and having a milk allergy child before [.] or is it something else that's going on because he was treated as a milk allergy as well all 3 of them were in the end [.] and er he goes no what are you here for (slightly shouts) because he's got a bloody rash even the child minder because I was at work the child minder phoned me up you see to say come home your child's got a rash I think he needs to go doctors and when I looked at him I thought yeah he has not seen that one before [.] and I took him to the doctors and then I got the G.P. treating me like I was [.] a neurotic mother in there because I needed attention for myself

(Participant B, p. 21, section 30)

Participant B feels that other people don't understand as they assume that she is trying to meet her own needs through her children. She feels irritated by this perception that she feels other people have of people with a diagnosis of BPD. Participant B also discussed that her children have had a

positive experience of her parenting, despite other people not understanding her:

> …my kids are happy they're running around they love me to bits [..] you know what I mean they're doing everything they should be doing [..] and it's just me that sometimes needs the extra help

> (Participant B, p.38, section 46)

Participant B perhaps feels that she herself has not caused her children to have negative experiences but rather that other people have impacted on her ability to parent how she wants to, which has resulted in some negative experiences for her children. She feels that other people have not understood that it is her that sometimes needs the extra support and that it is assumed that her children will have problems.

3.6.2 Theme 3b: Being viewed as a diagnosis not as an individual

Participant B discussed how she believes her diagnosis has had a negative impact on children in terms of not seeking support because of how other people perceive her diagnosis:

> …it prevents you [.] from seeking the right help it prevents you doing the right thing [.] the things that every other mother would do

[..] makes you think twice about doing it [.] when you've had a [.] an experience of the bad help [.] which didn't help it just destroyed

(Participant B, p. 26, section 33)

Participant B has felt unable to ask for help for her children due to how other people see her mental health diagnosis. She feels that this perception then impacts on her children, as they do not get the help that they need. This perception impacts on her ability to parent, as she says she would like to. She refers to this again here:

…people don't understand erm [..] mental illness anyway um [.] like I said when you're given a title to that um [.] um mental illness (clears throat) [.] er [..] they don't want to kind of like learn about it [.] they'd rather kind of like [.] put it at the back of their mind and [..] say well if you really want to get over it you can

(Participant A, p.14, section 22)

Participant A discusses here that other people do not want to understand mental illness. She implies that it is seen as something that you can have control over and that other people think she is making a choice to be unwell.

87

Two participants talked about how they felt professionals perceived them:

I think probably what the social services saw [….] was a woman with mental health problems [..] and probably wrote me off [..] for being thick and stupid and [..] not being able to look after the children [….] so I think as far as [.] social services were concerned they'd just written me off

(Participant C, p.16, section 23)

Participant C feels that women with mental health difficulties, specifically BPD, are not viewed as acceptable parents by social services. She feels that she was not given a chance and that the label of having a mental health problem means you are automatically seen as not being good enough. She discussed how she felt social services only saw one side of her parenting and the impact that this had on her:

Did make me very angry and frustrated [….] because I could see [..] some of the good bits that I was doing [..] then I broke back down um [.….] yeah just very angry and frustrated [..] that they didn't see the whole picture

(Participant C, p.17, section 24)

Participant B also discussed how professionals viewed her, as a new mother:

Participant B:…there they were in hospital treating me like I was a [.] new mum [.] young new mum which is worse and didn't know what I was on about [..] but my natural instincts were there

Interviewer: So you felt your natural instincts were there but other people [.]

Participant B: Put me down

(Participant B, p.3, section 4)

Participant B also experienced stigma as she felt that when she had her baby she was seen to be incompetent by hospital staff. She relates this to being viewed as a new mother. Participant B discussed that she felt that people 'put her down' despite her feeling that she knew instinctively how to be a mother. Later on in the interview, participant B discussed how she felt she was treated in relation to being a mother with a mental health diagnosis:

…it then stops you asking for help [.] for your child [..] all those experiences build up [.] and then it gets to a point where you've just got no [.] faith in them at all [.] and um you haven't got them on a

pedestal no you're just arseholes (laughs) [..] you say you're

listening but you're not listening if you know what I mean [..] people

haven't listened they're judgmental [..] if you fight your corner [.]

then [.] oh prove it see you are off your rocker [.] and you're just

trying to fight your corner just like any body else would

(Participant B, p.32, section 41)

…the discrimination that's towards [.] mothers with mental health is

not good [.] and they think it's the mental health that prevents you

from seeking help for your child when it's not it it's how we get

treated when we take our child to get [.] sorted out [.] that's when

it's a disability

(Participant B, p.36, section 44)

In both of the above extracts, participant B discusses feeling that she

has experienced stigma from health professionals in relation to having a

diagnosis of BPD. She believes that this stigma prevents her from asking for

help for both herself and her children. She has experienced having to 'fight

a battle' to get the support that she and her children need.

Participant B talked about how she does not disclose her mental

health difficulties to other people due to be seeing seen as a diagnosis rather

than an individual:

Interviewer: Do you feel that people have held it against you?

Participant B: Mmm

Interviewer: In what way?

Participant B: Well I don't tell people [..] that I have mental health

problems [..]

(Participant B, p.27, section 36)

Earlier in the interview she discussed how people knowing about her

mental health diagnosis impacts on her children:

I asked for help for my daughter [..] and instead of getting help we

got sort of the attitude of oh you have a mental health problem panic

panic panic [.] oh you must be the problem to your child

(Participant B, p.18, section 27)

Interviewer: So you said that you asked for help?

Participant B: Yeah like what is wrong with this child [.] and instead

of sorting her out they just decided oh mother's got mental health

problems [.] she must be the problem [..] you know

Participant B feels that the stigma she experiences in relation to her mental health diagnosis can also affect her children in terms of the help that they receive. She discusses how being treated negatively leads her to not want to ask for support:

…you know you're doing what is right you know you haven't done anything wrong [.] but because of the prejudice that's surrounding parents with mental health [.] they're not worried about the fathers with mental health so much it's mothers with mental health [..] it prevents you [.] from seeking the right help it prevents you doing the right thing

In relation to this she shared that she felt that services are not honest:

…oh yeah we're here to help you and this that and the other work out what you need as a family no you're trying to work out whether I'm a bad parent or not see whether you need you need to take my child off me or not [.] don't give me that old bullshit (laughs) we all know you're there for the kid and not for the family

There is a sense of services being untrustworthy and being prejudiced towards mothers with a mental health diagnosis. Participant B described that she had had a parenting assessment and the outcome of this:

…it was all positive [.] and they expected me at the end of it to be happy that they found me to be a fantastic parent and asked me if I'd be a foster parent [.] and they expected me to be happier with it [..] yeah I was pleased that I'd proved to them [.] but why should I have needed to prove to them [.] I knew that I was a good parent already

(Participant B, p.24, section 32)

Participant B is highlighting that she felt irritated that she had to prove that she was able to parent appropriately to the relevant services. She seems to feel that she has been targeted and demonized by services. She has not felt supported by services rather that they have hindered her willingness to ask for help.

Chapter 4: Discussion

4.1: Overview

This chapter begins with a brief summary of the research findings and considers the similarities and differences between participant's experiences. Links are made with the current literature and reflections on the research process and analysis are included, taken from the researcher's reflective diary. Limitations of the current study are outlined and discussed. Clinical implications are considered followed by ideas around areas for future research. The chapter concludes with a summary of overall conclusions from the current study.

4.2 Summary of Research Findings

This study aimed to explore how mothers with a diagnosis of BPD make sense of their experiences of being a parent. Analysis revealed three superordinate themes that described individual's experiences in terms of being a bad mother, needing to be understood and accepted by children, and lack of support.

Participant's discussed how they saw themselves as parents. Some participants talked about feeling undeserving of their children due to evaluating their parenting skills in a negative way. This was also related to a general view of the self as not deserving of anything good. One participant discussed questioning her parenting in terms of what a 'good mother' would do in certain situations. Self criticism and not feeling as a mother 'should'

was also evident for the majority of participants, in relation to their parenting, with some participants comparing themselves to how they felt they 'should' feel and behave as a mother. Some participants shared the experience of feeling that they needed to protect their child from themselves as they viewed themselves as dangerous and potentially damaging. Two participants described that they had felt emotionally cut off from their children and other people. However, one participant felt that this was a protective strategy that helped to keep her children safe which she saw as being a permanent way of being, whilst the other participant saw this as a temporary response that was due to environmental factors such as isolation

Participants discussed the importance of their children understanding their difficulties and needing support from them. It seemed that some participants viewed their children as being in a parental role at times as they discussed needing support from their children. One participant seemed to fear her child abandoning her, whilst another participant discussed feeling frustrated that other people see her as meeting her own need through her children. A number of participants discussed dilemmas around disclosure of difficulties to their children. One participant felt that her children knowing the truth about her difficulties was very important because she felt that mental illness in general is not understood. It was important for her to know that her children understood and she attributed this ensuring her children's wellbeing. For this participant, being able to disclose to her children herself was seen as important, rather than someone else telling them. In contrast to this, one participant felt that she did not want her children to know about her difficulties, as she feared 'damaging' them and being a burden. Another

participant also discussed not wanting to disclose her difficulties to her children but described how this changed, as her children got older. One participant spoke about her child being aware of her difficulties despite her trying to keep this hidden. She spoke about the impact she feels her difficulties have had on him.

All participants discussed the impact that their difficulties had had on their children. Two participants thought about this in terms of whether they had caused their children to have their own difficulties. One participant discussed how having a diagnosis of BPD had impacted on her children in terms of the how people responded to her and how this in turn impacted on whether she felt able to seek help for her children

Some participants reported experiencing a lack of support as a mother with a diagnosis of BPD. It was felt that this lack of support was due to people outside of the family not understanding and potentially being dangerous. A number of participants expressed frustration about how they had been treated by social services. They felt that they had been viewed as a diagnosis and that this meant people were more likely to notice bad things about their parenting rather than good. One participant felt that her experiences of services had predominately been negative. She described feeling judged and having to 'fight' to keep her children and related this to having a mental health diagnosis, as she felt stigmatised.

4.3 Interpretation of findings in relation to the literature

The experiences discussed by each participant had some within group similarities and differences. Accordingly there were some similarities and differences in terms of comparing the current study to the research literature. Some of the experiences that participants discussed were related to difficulties that are often viewed as symptoms of having a diagnosis of BPD, such as difficulties with emotional containment and dichotomous thinking (Sheffield et al., 1999; Coifman, Berenson, Rafaeli & Downey, 2012). Saunders and Arnold (1993) conceptualise these difficulties as an internalisation of earlier trauma experiences. A number of participants within this study made reference to early traumatic experiences, as is well established within people that have a diagnosis of BPD (Weaver & Clum, 1993).

A number of the experiences shared by participants seemed to be common in general for mothers with mental health difficulties. A recent systematic review identified a number of themes that are prevalent when asking mothers with severe mental illness about their experiences (Dolman et al., 2013). Stigma from the wider system was one theme that was identified, with mothers with severe mental illness saying that they are less likely to seek help because of perceived stigma (Ackerson, 2003). This was very prevalent for one participant in particular in the current study that made reference to fearing asking for help, as she then felt blamed. Another common theme identified in the systematic review was societal ideas around what being a good mother means and how being mentally ill does not fit with this ideal (Davies & Allen, 2007). A number of participants in the

present study made reference to conceptualising their parenting as being 'bad'. Participants also seemed to experience guilt and shame around not living up to these expectations that they and society had placed on them. Edwards and Timmons (2005) identified that self stigma and viewing the self as a bad mother was common amongst mothers with a diagnosis of mental illness. The present study also found that self criticism was a common theme, and viewing the self as a bad mother.

Other similarities between the current study and existing literature of experiences of mothers with severe mental illness were the experience of feeling a failure (Davies & Allen, 2007). A number of participants in the present study discussed that they felt they had failed to protect their children from themselves in some way. Some participants in the current study discussed that they felt their children had 'missed out' on things and had had to 'grow up quickly'. The systematic review by Dolman et al. (2013) similarly identified that mothers with a serious mental illness had concerns around their children having to take on too much responsibility (Ackerson, 2003). Some participants in the present study discussed why they felt they had been able to retain custody of their children in relation to the support that they had received. One participant spoke in length about fearing seeking help and support. The current literature suggests that mothers with a severe mental illness may be reluctant to seek help, as they fear losing custody of their children (Khalifeh, Murgatroyd, Freeman & Johnson, 2009). This is similar to what was discussed by one participant in the present study as she referred to feeling that professionals want to 'use her children against her' and that she has to prove she is able to parent her

children appropriately. A number of participants in the current study discussed feeling blamed by professionals, similar to what Wilson and Crowe (2009) noticed in their research.

Some differences that were noticed in the current research compared the existing literature were that although impact on the child was discussed; this was in relation to fearing how emotional responses would impact on children's behaviour. Participants in this study did not report any fears of secondary stigma from other parents and stigma towards children by other children, as was found in previous research (Ueno & Kamibeppu, 2008; Diaz-Caneja & Johnson, 2004). Isolation has been found to be a common experience amongst mothers with severe mental illness (Dolman et al., 2013), however this theme did not appear to be as prominent in the current study.

Some experiences that were shared in the present study seem to have been identified in other research that has examined the general experience of being a mother, with or without a mental health diagnosis. For example, a finding from the current research was that some participants seemed to be self critical about their parenting abilities, and felt that they did not feel as they 'should' towards their child. This self criticism seems to be a common experience amongst mothers in terms of directing criticism towards the self if you are unable to mother as you feel you should. This has been identified previously in mothers who have had difficulties with breastfeeding (Williamson, Leeming, Lytlle & Johnson, 2012).

In summary, it seems that some of the experiences identified in the current study are common to all mothers or mothers who have been diagnosed with a severe mental illness. However, some of these experiences may be more specific to mothers who have a diagnosis of BPD.

4.4 Reflective Diary

As previously described, the researcher kept a reflective diary throughout the whole research process in order to aid with bracketing off the researcher's own assumptions. The researcher particularly reflected on the process of the research itself and the decision making process during the analysis. Both the process of the research in general and process of analysis are discussed below.

4.4.1 Process of Research

Recruitment for this study was particularly challenging. A number of participants did not attend interviews and re-arranged a number of times, with the last participant attending an interview approximately a month before submission. This suggests some uncertainty around talking about experiences of being a mother. The researcher noted that four out of the five participants disclosed that they had experienced losing a child either at a young age or through miscarriage. There seemed to a general experience of trauma around having and raising children. The researcher felt wary about asking questions around this in terms of the emotional response that this

may have triggered for some people. The researcher also discussed these concerns in the reflective essay prior to commencing recruitment. Although the researcher did not ask any specific questions around trauma experienced in relation to having children, some participants had strong emotional response to the questions asked. The researcher reflected that this might have been why this research had not been carried out previously, as there is a concern around how people with a diagnosis with BPD will respond to being asked about being a parent. This seems to be a specific concern related to this diagnosis as an abundance of research has been carried out that asks mothers with a mental health diagnosis about their experiences of parenting. The majority of participants reflected on negative experiences, despite not being directed to do this. Two participants found the interview particularly challenging and requested that the interview finish due to finding it difficult. This made the researcher reflect on how this topic generally seems to be difficult for people with this diagnosis to discuss. The emotional response that one participant had seemed to make the recruiting service more wary about approaching participants to take part in the study. This is understandable, again it seems that people have concerns in general around what will happen if someone with this diagnosis finds something difficult. As is stated in the method section, all participants knew what the research was about but perhaps some found it difficult to recognize that they might find it particularly challenging to talk about these sort of experiences. These concerns also made the researcher more wary about asking participants to provide more information at times.

It is interesting that all of the participants in the study had older children apart from one. The researcher reflected on this and questioned whether this was due to the service context, for example, that it is mainly slightly older women that attend this service. Another possibility is that only older females seek help or get referred into specialist personality disorder services. The researcher also considered that perhaps the team only felt able to approach women with older children to be interviewed, as they feared the emotional response and impact on those with younger children. The study criteria also excluded potential participants that had current child protection issues. It may have been that those with younger children had current child protection concerns. The researcher also thought about this decision around who to include and exclude from the study. It was reflected that perhaps it would have been appropriate to include people with these concerns, as professionals would already be aware of any current risk management issues. However, the researcher also reflected that including people with these concerns may have skewed the sample in that people may have had more negative experiences, or they may have found it difficult to discuss current difficulties that were ongoing in relation to child protection.

4.4.2 Process of Analysis

The researcher also used the reflective diary and reflective essay when carrying out the analysis. The researcher questioned whether she noticed certain themes more than others due to being aware of current stereotypes around BPD. This may have made certain themes more

prominent and will have impacted on the researcher's interpretation of the analysis. The researcher found the decision making process of categorising themes challenging, particularly as participants' experiences were quite distinct in many ways. This was an ongoing process and feedback was utilised from supervisors around this.

4.5 Demonstrating Quality

It is important in qualitative research that a plausible and transparent account of the data is provided so that the reader can explicitly see where and how the researcher's ideas have developed, in order to demonstrate quality research. As validated measures and statistics are not used, there needs to be a way that qualitative research can be evaluated to assess the quality. Elliott, Fischer and Rennie (1999) and Yardley (2000, 2008) have suggested criteria that can be used to evaluate qualitative research, regardless of the theoretical orientation of the study. Smith et al. (2009) recommend both of these criteria when evaluating the quality of an IPA study. Yardley's (2000) criteria are outlined below with some reference to Elliott et al. (1999) criteria.

4.5.1 Sensitivity to context (Yardley, 2000)

Sensitivity to context can be demonstrated in the background detail that is obtained from participants and shown in an understanding of the previous literature on the topic. Elliott et al. (1999) report the importance of

situating the sample within qualitative research. Demographic information was collected from participants so that the researcher had some understanding of the participant's world before the interview began. The analysis uses direct quotes from participants and links with the existing literature are made, this also demonstrates sensitivity to context.

4.5.2 Commitment and rigour (Yardley, 2000)

To carry out an IPA study and analysis effectively requires attentiveness to the participant and what they have said. This is evidence of commitment to the study. The researcher carried out a literature review in the area and spent time reading about IPA and papers that had been written that used IPA. The researcher also transcribed the data and spent time reading and re-reading the data so as to be fully immersed and familiar with it. Rigour is demonstrated through the careful selection of the sample and through interview technique demonstrated in the depth of data collected. Quotes are used to evidence each theme, which also demonstrates rigourousness of the data. A member of the research team who is experienced in using IPA reviewed some of the coded transcripts. This ensures credibility, as discussed by Elliiott et al. (1999).

4.5.3 Transparency and coherence (Yardley, 2000)

A detailed account of the analytic process is important in demonstrating quality (Henwood & Pidgeon, 1992). The researcher has

demonstrated transparency by outlining how participants were selected, how the interviews were run, and how the analysis was conducted. A coherent hierarchical structure of the analysis is presented. The researcher kept a reflective diary throughout the study and analysis in order to assist with transparency. Drafts of the write up and analysis were read by research supervisors to help ensure coherence. Elliott et al. (1999) state that the research should be grounded in examples, as part of ensuring transparency. The researcher used quotes from participants to demonstrate each theme. Brocki and Waerden (2010) state that the acknowledgement of researcher preconceptions and beliefs can increase transparency. A statement of the researcher's position is included.

4.5.4 Impact and importance (Yardley, 2000)

This refers to the research contributing to the current literature or practice within the area. Stepp et al. (2012) recently published a "call to action" stating that more research needs to investigate parenting within BPD. This research fulfils this recommendation.

4.5.5 Owning one's perspective (Elliot et al., 1999)

Elliot et al. (1999) discuss the importance of the researcher identifying their own background and relationship to the topic area. It is important to be able to reflect on your own preconceptions (Smith, 2007) and be aware of how they may impact on your interpretation of the data.

The researcher ensured this by writing a reflective essay prior to recruiting participants for the study. The researchers supervisors read this essay and were able to help the researcher to think about how this may impact on the analysis and interviewing style. The researcher attempted to bracket off her own views during analysis of the data by using this reflective essay and keeping a reflective diary throughout the process. A clear statement of the researcher's position is also included in section 4.5.6.

4.5.6 Researcher's position

As previously discussed, transparency and owning one's perspective is important within qualitative research so that the reader can have some understanding of the context that the researcher is making interpretations from. The researcher was female undertaking clinical psychology doctorate training. The researcher does not have any preference for a particular theoretical model.

The researcher has an interest in BPD and has known people with this diagnosis socially and worked with people with this diagnosis in a therapeutic context. The researcher strongly feels that people with this diagnosis can often be viewed negatively by mental health services. The researcher also questions the diagnostic term of personality disorder in terms of the implication that someone's personality is disordered, rather than that they have mental health difficulties. The researcher feels that this term has negative connotations.

4.6 Limitations

This study has a number of limitations. Firstly, given the qualitative methodology, the study sample was small and may not be representative of larger populations. As previously discussed, recruitment for this study was particularly challenging and further themes may have been identified if it had been possible to continue with recruitment. Homogeneity of participants was also difficult to ensure as one participant had a young child whilst the rest had older children. This meant that reflections on earlier parenting experiences were more limited and were perhaps subject to memory bias. The participant with younger children did share some different experiences to other group members but the group as a whole all had varying experiences, suggesting that homogeneity was not compromised by this issue. The researcher did not collect information on whether participants had a partner or how long they had been receiving support for. This information would have been useful in terms of providing more context to the data. The participants in the study disclosed a number of traumas in relation to having children. This may be an over-representative sample. As participants chose whether to take part in the study or not there may have been a selection bias. People who volunteered to take part may have felt more strongly about their identity as a mother and that is why they agreed to participate in the study.

The researcher's position has been made clear in the methodology section of this paper and further reflections on the research process have been presented in this chapter, through the use of a reflective diary and the writing of a reflective essay that was reviewed by the researcher's

supervisors. It is the author's opinion that the researcher's experiences and assumptions that may have influenced the research and analysis have been examined and held in mind throughout the research process. However, given the methodology used the results of this study remain subjective and are based on the researcher's own interpretations and experiences. The researcher, whilst attempting to bracket her assumptions as far as possible, may have searched for themes within the data which helped to explain those experiences which were similar to her own beliefs about BPD.

As the study relied on participants providing information about themselves, it may have been subject to social desirability biases in terms of the information that participants felt comfortable to share. For example, it may have been more difficult for participants to share information about themselves that they may have perceived as being overly negative. Similarly, the researcher stated at the start of the interview about when confidentiality would have to be broken. This may have limited participants' responses for fear of this.

Researcher characteristics such as age, gender, profession may have influenced the information that participants provided. For example, participants may have perceived the researcher to not have children herself due to perceived age and that she does not wear a wedding ring. This may have impacted on how participants responded to the questions or how much information that participants felt willing to share. This will have therefore impacted on the findings and conclusions of this study.

The interview schedule used focused on obtaining information about participants experiences of being a mother. This tool was used in order to

support meeting of the research aims. However, this may have narrowed the breadth of accounts meaning that some aspects of experiences were not explored. Participants may have not shared some aspects of experience as they may have felt that it did not fit in with the interview schedule. Similarly the interviewer's response to the participants' responses may have encouraged them to talk further about a particular topic which was of interest to the researcher but which may have been less important to the participant. As discussed earlier, due to the emotional response of some participants, the researcher may have not asked for further detail on some responses due to concerns around this. This may have impacted on what participants talked about and therefore the findings of the study.

4.7 Clinical Implications

The findings of this study suggest that the experience of parenting for mothers with a diagnosis of BPD can be challenging and traumatic. Some people discussed evaluating their whole sense of self based on their parenting skills.

Some participants felt that they had not been treated in a positive way by social services and that they had just been treated as a diagnosis rather than as an individual. Stigma and negative biases were also discussed and participants seemed to feel it was important that clinicians did not make assumptions about their inability to parent based on their diagnosis. A further clinical implication is for clinicians and services to be aware of the emotive impact of this subject and to perhaps discuss further with people

about trauma related to death of children rather than focusing purely on parenting ability.

As the experiences of participants differed, this suggests that it is important to not make assumptions based on diagnosis but rather to treat people as individuals and listen to their experience. It seems important that people are supported based on their experiences rather than within a diagnosis.

It would seem that parenting interventions could be useful for this client group. It has been argued that mentalization-based interventions may be useful for expectant mothers in order to help them explore their own identity as a mother and that of their unborn child (Markin, 2013). In Colchester, a personality disorder service called the Haven was set up which involved the use of parenting classes tailored to the needs of parents with a personality disorder diagnosis. Parents that use this service reported that they find it useful (Parental Mental Health and Child Welfare Network, 2009). However, there is a conspicuous absence of suggested, validated treatment approaches or support programmes for mothers or parents, particularly those who have a diagnosis of personality disorder given the concerns raised about the potential negative impact of the disorder on children.

4.8 Future Research

In addition to future research that addresses the limitations of this study, it would be useful for future research in this area to ask mothers with a diagnosis of BPD about their experiences of parenting their children at different ages. It would be helpful to carry this research out with parents that have children all of a similar age as this would reduce the impact of memory biases. Experiences may differ based on the age of the child and there may be some age groups that parenting may be more difficult than others or different issues may arise. It may also be useful to investigate experiences in mother's that share similar experiences rather than a diagnosis. As this research shows, it is not always useful to categorise people by diagnosis, as their experiences can still be very different.

Further research could also look further into what support people would like and what they think would help them. A parenting intervention has been devised for mothers with a diagnosis of BPD and their children, as discussed in the introduction. Future research could look at evaluating the idea of this and the intervention itself further.

4.9 Final Conclusions

This study explored the lived experience of being a mother with a diagnosis of BPD. Participants described their experiences in terms of how they viewed themselves as a mother and the importance of being understood and accepted by your children. The lack of understanding and stigma

experienced were also viewed as important. The findings of this study

contribute to the literature that already recognizes that further support and

research is needed to support mothers with this diagnosis further.

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Appendix A: Participant Invitation

You are being invited to take part in a research study that is being completed as part of the researcher's University course at the University of East Anglia.

This study wants to find out about experiences of parenting in mothers who have a diagnosis of Borderline Personality Disorder. It wants to find out about what support people have had with parenting their children, and whether anything else would have been helpful.

You are being invited to take part because you are a parent who is currently receiving support from a specialist service for people with Personality Disorder.

This pack has more information about the study and some forms to complete if you are interested. This information explains in more detail what participation in the study would involve and the purpose of the research. It also explains how you can take part if you wish.

If you have any questions about the study, please do not hesitate to contact the researcher, Katie Ainsworth (Trainee Clinical Psychologist):

Email: k.ainsworth@uea.ac.uk

Thank you for taking the time to read this information.

Katie Ainsworth

Researcher

Participant Identification Number: Version 3: 19.07.13

PARTICIPANT INFORMATION SHEET

Title of project: Experiences of parenting in mothers who have a diagnosis of Borderline Personality Disorder (BPD)

Name of researcher: Katie Ainsworth (Trainee Clinical Psychologist)

You are being invited to take part in a research study. Before you decide whether to participate it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please contact us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of this study?

The purpose of this study is to ask mothers with a diagnosis of BPD about their experiences of parenting their children. The research aims to ask about both positive and more difficult experiences in order to develop future support for other people in a similar situation.

Why have I been chosen?

You have been chosen because you are currently receiving support from a specialist Personality Disorder Service. We are hoping to recruit 6-8 people in total. We are interested in recruiting people who have biological children that live at home with them or older children who no longer live at home.

Do I have to take part?

It is up to you to decide whether or not to take part. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time or a decision not to take part will not affect the treatment you receive, now or in the future.

What will happen to me if I take part?

If you decide to take part, the researcher will contact you to arrange a convenient time for you to attend an interview at [service name]. The interview would just be with you and the researcher. The researcher will ask you to talk about the experiences you have had with parenting your children. It is up to you what experiences you share. The aim of the interview is to try and understand what these experiences were like for you.

The interview will be tape recorded and will last for approximately one hour. You will be reimbursed for your travel expenses (up to a maximum of £5).

What are the possible disadvantages and risks of taking part?

Taking part in the interview will take up approximately an hour and a half of your time. Talking about parenting your children could potentially be difficult for you to talk about. We encourage you to only share as much as you feel comfortable with during the interview. There will be time at the end of the interview to talk through with the researcher about anything that you perhaps found difficult. The interview will be arranged at a time that you are able to access support from [service name] upon completion of the interview, if needed.

What are the possible benefits of taking part?

There are no individual benefits in taking part. However, we hope that the information we gain from this research will help us to learn more about the experiences of mothers who have a diagnosis of BPD. This will then help in developing future services.

What happens when the research finishes?

The researcher will write up the results of the interviews. Direct quotes will be used in this so confidentially cannot be guaranteed.

However, all identifying information, such as names, will be removed. The results of the study will be shared with people who work at the Complex Cases Service / Number 63. The research study will be submitted to the University of East Anglia as part of the researcher's course requirements. The results may also be published in academic journals. If you would like to receive a summary of the results please indicate this on the consent form.

What if I am unhappy with any aspect of the study?

If you wish to complain, or have concerns about any aspect of the way you have been approached or treated during the course of this study, you can contact the researcher's supervisors at the University of East Anglia. Dr Williams and Dr Hodgekins' contact details are on the following page.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential. During the study, all data will be stored in a locked cabinet and on an encrypted memory stick. Only the researcher and University supervisors will have access to this. After the study has finished, the data will be stored securely by the University of East Anglia and retained for 5 years. After this time, the data will be destroyed securely by the University.

If you decide to withdraw from the study before it has finished, all your data will be destroyed.

If you tell the researcher about any current risk to yourself or others during the course of the interview, the researcher will have to pass this information to your care co-ordinator. The researcher would let you know that they needed to do this

Who is organising and funding the research?

The research is part of the researcher's course, the doctorate in clinical psychology at the University of East Anglia. As a Trainee Clinical Psychologist, the researcher is employed by Cambridgeshire and Peterborough NHS Foundation Trust.

Who has reviewed the study?

This study has been reviewed and approved by an NHS Research Ethics Committee.

Contacts for further information/complaints:

Katie Ainsworth (researcher and Trainee Clinical Psychologist):

Email: k.ainsworth@uea.ac.uk

Dr Deirdre Williams (researcher's primary supervisor and course clinical tutor):

Email: deirdre.williams@uea.ac.uk

Telephone number: 01603 593310

Dr Joanne Hodgekins (researcher's secondary supervisor and course clinical tutor):

Email: j.hodgekins@uea.ac.uk

Telephone number: 01603 591890

Appendix C: Consent to Contact Form

CONSENT TO CONTACT FORM

Title of project: Experiences of parenting in mothers who have a diagnosis of Borderline Personality Disorder

Name of researchers: Katie Ainsworth

Please initial box

1. I am interested in taking part in an interview ☐

2. I have read and understand the Participant Information Sheet (dated: 19.07.13 version 3) about the interview. ☐

3. I give permission for the researcher to contact me on the telephone number below to discuss the research, what it would entail, and whether I would like to take part. ☐

4. I understand that if I no longer wish for the researcher to contact me or change my mind about taking part, I can withdraw from the research at any time. ☐

Name and date: ....

Signature: ....

Contact Phone Number:..

<u>Please return this form in the stamped addressed envelope provided or place in the drop box provided at the service.</u>

Thank you.

Participant Identification Number: Version 3: 19.07.13

CONSENT FORM

Title of project: Experiences of parenting in mothers who have a diagnosis of Borderline Personality Disorder

Name of researcher: Katie Ainsworth

Please initial box

1. I have read and understand the Participant Information Sheet (dated: 19.07.13, version 3) about the interview.

2. I understand that I do not have to take part in the interview and that I can stop the interview at any time without giving any reasons. I understand that if I decide to stop being interviewed, this will not affect the help I am given at [service name] either currently or in the future. I understand that the interview will be audio recorded and anonymised, and direct quotes will be used in the written results.

3. I understand that I do not have to share any information that I am uncomfortable with during the interview.

4. I understand that the researcher will need to inform my care co-ordinator if I disclose any current risk to myself or others.

5. I would like a written summary of the research findings.

Name: ....

Signature: ....

Date:……………………………………………………………………….

Thank you.

Appendix E: Demographics Questionnaire

Demographics Questionnaire

Please do not write your name on this form. Your responses will be kept anonymous. Please indicate your response.

1. Your age in years:

……………………………………………………………………………

2. Your ethnicity:

……………………………………………………………………………

3. Your employment status:

……………………………………………………………………………

4. Number of children:

……………………………………………………………………………

5. Information about your biological children:

Child One:

Age:
……………………………………………………………………………

Gender:
…………………………………………………………………………..

Do they currently live with you?
....

Child Two:

Age:
…………………………………………………………………………

Gender:
…………………………………………………………………………..

Do they currently live with you?

....

Child Three:

Age:

....

Gender:

....

Do they currently live with you?

....

Child Four:

Age:

....

Gender:

....

Do they currently live with you?

....

Child Five:

Age:

....

Gender:

....

Do they currently live with you?

....

Child Six:

Age:

....

Gender:

....

Do they currently live with you?

....

Thank you.

Appendix F: Interview Schedule

<u>Interview Schedule</u>

Version 1: 19.07.13

Main question: Can you tell me about your experiences of parenting your children?

Prompts:

- What has parenting been like for you?
- What comes into your mind when I ask you about your experiences?
- How do you make sense of your experiences?
- What do these experiences mean to you?
- Can you tell me a bit more about that?
- I really want to make sure that I have understood you, *(summarise what participant has said)*, is that right?
- Can you describe that a bit more to me?

Appendix G: Ethical Approval Documentation

NRES Approval

NHS

Health Research Authority

NRES Committee East of England - Essex

London REC Office
Health Research Authority
Ground Floor, Skipton House
80 London Road
London
SE1 6LH

Telephone: 020 797 22568
Facsimile: 020 797 22592

24 May 2013

Miss Katie Ainsworth
Clinical Psychology Doctorate
School of Medicine, UEA.
Norwich
NR4 7TJ

Dear Miss Ainsworth

Study title:	**Experiences of parenting in mothers who have a diagnosis of Borderline Personality Disorder: An exploratory study**
REC reference:	13/EE/0029
IRAS project ID:	114978

Thank you for your email received on the 18ᵗʰ May 2013. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 19 April 2013. You stated in your email that point 1 and 2 of the conditions of the favourable opinion listed below do not apply to the questionnaires or Participant Information Sheets submitted:

1. The date of birth is not recorded in the record form EDS group baseline questionnaire, as this is 'Patient identifiable'. Age should be enough, and preferably banded e.g. 21-25, 26-30 etc.

2. The word 'Patient' in documents such as 'Patient Information Sheet' be re-titled 'Participant Information Sheet' and edited throughout, including footers. Patients become participants when they give consent to enter a study.

We apologise for this error and this letter acknowledges that the above is not applicable to your study as stated in your email response.

Documents received

The documents received were as follows:

Document	Version	Date

Covering Letter	Email from Katie Ainsworth	18 May 2013
Other: Mark Sheet from Nicola Shearing		24 April 2012
Participant Information Sheet: Focus group	Version 3	18 May 2013

Approved documents

The final list of approved documentation for the study is therefore as follows:

Document	Version	Date
Covering Letter	Email from Katie Ainsworth	18 May 2013
Evidence of insurance or indemnity	Zurich Municipal	15 May 2012
Investigator CV	Deirdre Williams	
Investigator CV	Katie Ainsworth	24 December 2012
Investigator CV	Dr Joanne Hodgekins	
Letter from Sponsor	From Yvonne Kirkham	21 December 2012
Letter of invitation to participant	1	30 March 2013
Other: Research Supervisor's report		07 February 2012
Other: Focus Group Ground Rules	1	30 March 2013
Other: Mark Sheet from Nicola Shearing		24 April 2012
Participant Consent Form: Consent to Contact	1	02 April 2012
Participant Consent Form	1	02 April 2012
Participant Consent Form: Consent to Contact form	2	30 March 2013
Participant Consent Form	2	30 March 2013
Participant Information Sheet: Focus Group	1	06 February 2012
Participant Information Sheet: Interview	1	06 February 2012
Participant Information Sheet: Interview	2	30 March 2013
Participant Information Sheet: Focus Group	2	30 March 2013
Participant Information Sheet: Focus group	Version 3	18 May 2013
Protocol	4	24 December 2012
Questionnaire: Demographics Questionnaire	1	02 April 2013
REC application	Submission code: 114978/4042 75/1/86	18 January 2013
Response to Request for Further Information	Kaite Ainsworth	30 March 2013

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

at all participating sites.

| 13/EE/0029 | Please quote this number on all correspondence |

Yours sincerely

Mrs Bukky Gibson
Committee Co-ordinator

E-mail: nrescommittee.eastofengland-essex@nhs.net

Copy to: Yvonne Kirkham,
              Beth   Muldrew, Cambridgeshire and Peterborough NHS Foundation Trust

R&D Approval

Cambridgeshire and Peterborough **NHS**

NHS Foundation Trust

Understanding children, young people and families

Research and Development Department

3 July 2013

R&D Ref: M00537

Dr Amanda Spong
Complex Cases Service - Springbank
Cambridgeshire and Peterborough
NHS Foundation Trust
Fulbourn Hospital
Cambridge CB21 5EF

Joint Research Office
Box 277
Addenbrooke's Hospital
Hills Road
Cambridge
CB2 0QQ

Direct Dial: 01223 596472 ext 6472
E-mail: beth.muldrew@cpft.nhs.uk
www.cpft.nhs.uk

Dear Dr Spong

Re: 13/EE/0029 Experiences of parenting in mothers who have a diagnosis of Borderline Personality Disorder

In accordance with the Department of Health's Research Governance Framework for Health and Social Care, all research projects taking place within the Trust must receive a favourable opinion from an ethics committee and approval from the Department of Research and Development (R&D) prior to commencement.

R&D have reviewed the documentation submitted for this project, and has undertaken a **site specific assessment** based on the information provided in the SSI form, and I am pleased to inform you that we have no objection to the research proceeding within CPFT.

Sponsor: University of East Anglia

Funder: University of East Anglia

End date: 01/10/2013

Protocol: Version 4.0 dated 24 December 2012

Conditions of Trust Approval:
- The project must follow the agreed protocol and be conducted in accordance with all Trust Policies and Procedures especially those relating to research and data management. Any mobile devices used must also comply with Trust policies and procedures for encryption.

- You and your research team must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice and the Data Protection Act 1998 and are aware of your responsibilities in relation to the Human Tissue Act

HQ Elizabeth House, Fulbourn Hospital, Cambridge CB21 5EF.
T 01223 726789 F 01480 398501 www.cpft.nhs.uk

A member of Cambridge University Health Partners

2004, Good Clinical Practice, the NHS Research Governance Framework for Health and Social Care, Second Edition April 2005 and any further legislation released during the time of this study.

- Members of the research team must have appropriate substantive or honorary contracts with the Trust prior to the study commencing. Any additional researchers who join the study at a later stage must also hold a suitable contract.

- You and your research team must provide to R&D, as soon as available, the date of first patient first visit.

If the project is a clinical trial under the European Union Clinical Trials Directive the following must also be complied with:

- the EU Directive on Clinical Trials (Directive 2001/20/EC) and UK's implementation of the Directive: The Medicines for Human Use (Clinical Trials) Regulations 2004;

- the EU Directive on Principles and Guidelines for Good Clinical Practice (EU Commission Directive 2005/28/EC); and UK's implementation of the Directive: The Medicines for Human Use (Clinical Trials) Amendment Regulations 2006;

Amendments
Please ensure that you submit a copy of any amendments made to this study to the R&D Department.

Annual Report
It is obligatory that an annual report is submitted by the Chief Investigator to the research ethics committee, and we ask that a copy is sent to the R&D Department. The yearly period commences from the date of receiving a favourable opinion from the ethics committee.

Please refer to our website www.cpft.nhs.uk for all information relating to R&D including honorary contract forms, policies and procedures and data protection.

Should you require any further information please do not hesitate to contact us.

Yours sincerely
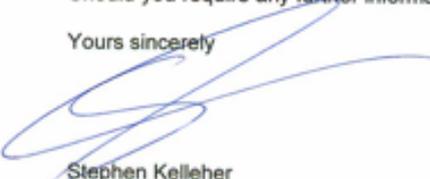
Stephen Kelleher
Senior R&D Manager

Cc Sue Steel, Contracts Manager, Research and Enterprise Services West Office, University of East Anglia, Norwich Research Park, Norwich NR4 7TJ

2

NHS
Health Research Authority

NRES Committee East of England - Essex

London REC Office
Health Research Authority
Ground Floor, Skipton House
80 London Road
London
SE1 6LH

Tel: 020 797 22561

09 August 2013

Miss Katie Ainsworth
Clinical Psychology Doctorate
School of Medicine, UEA.
Norwich
NR4 7TJ

Dear Miss Ainsworth

Study title:	**Experiences of parenting in mothers who have a diagnosis of Borderline Personality Disorder: An exploratory study**
REC reference:	13/EE/0029
Amendment number:	Am01
Amendment date:	08 July 2013
IRAS project ID:	114978

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

There were no ethical issues discussed, the Sub-Committee were content to approve the substantial amendment.

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

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Participant Consent Form: to contact	3	19 July 2013
Participant Consent Form	3	
Notice of Substantial Amendment (non-CTIMPs)	Am01	08 July 2013

Protocol	5	19 July 2013
Participant Information Sheet: Interview	3	19 July 2013
Interview Schedule	1	19 July 2013

Membership of the Committee

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

R&D approval

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

Statement of compliance

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

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

13/EE/0029:	Please quote this number on all correspondence

Yours sincerely

pp

Niki Bannister
Vice Chair

E-mail: NRESCommittee.EastofEngland-Essex@nhs.net

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

Copy to: Beth Muldrew, Cambridgeshire and Peterborough NHS Foundation Trust
Yvonne Kirkham

Dear …..

REC No: 13/EE/0029

Study Title: Experiences of Parenting in Mothers with Borderline Personality Disorder

Amendment no: 1

I can confirm that these changes do not affect research governance and therefore the study can continue.

Documents received:
• Favourable ethics approval letter issued by NRES Committee East of England – Essex (dated 19 August 2013)

Please refer to the conditions of approval for carrying out this study as outlined in the R&D approval letter dated 3 July 2013

Kind regards

Appendix H: Analysis Extracts

Extract from participant A transcript (pages 2-3)

mental illness	people can see other illnesses but with mental health you can't so people tend to kinda like [.] jump to conclusions that you're kinda like [.] mad and [.] if you're having to be in hospital like that [.] um so I think the boys have coped really well [.] with some difficult kinda like situations [.] um when someone's sectioned um and they're it's in front of children you don't know what they're [.] um is actually gonna be happening to the children or what's happening in their mind um [.] but they knew that um [.] if they wanted to know anything [.] then that's all they had to do was ask [.] um which I said from a really early age so whatever they ever needed to know and they could talk to me about it [..] um [.] as I said they both work so [.] pretty sure that um [.] I hope that whatever's happened in the past and the future that they can cope with [.] but it's always in the back of your mind that um you've spoilt their growing up [.] through sometimes being in hospital for long periods at a time [..] um but they still talk about it 'cos it still goes on so [.] but um [..] they come to [.] different meetings with me when I [.] have a big meeting once every 6 months [.] so they can keep	be a parent or that you will never come out of hospital? Treated differently with mental health problems, as you can't see anything physical. What does being mad mean? Unable to cope? Kinda like used a lot – uncertainty, not wanting to say for definite or say that knows for sure Children have coped well – importance of coping, said previously, wanting to prove good parent? Process of going into hospital – talking about self here but not using first person, distancing self from it? What will happen to the children – general phrase, what does this mean? Where will they go? What will they think of her? Will they be safe? Are they scared of their mother? Showing that did the right thing, reassuring self – would have asked if wanted to know about. Knowledge is important/powerful? Makes people feel safe? Importance of the truth again. Always said they could ask from young age – wanting children to be able to talk to her, unable to do this with own parents? Work discussed again – showing that difficulties did not impact on children. Unfinished sentences. Changes sure to hope. What else has happened in the past? Attributing responsibility to self as to how children now are. Thinking about past and future – what might happen in future? Coping. Spoilt – what does this mean? Spoilt childhood because of hospital admissions. Still ongoing – children talk about it still, past/present/future? Attended meetings – importance of knowledge again. Big meeting – in what way? Lots of
People think you're mad		
Coping		
Hospital admission process		
Sectioning and the impact on children		
Fears around keeping children safe		
Importance of knowledge and telling the truth, being open		
Coping		
Wanting children to ask questions – truth, being understood		
Children are able to work – not impacted		
Grew up quickly		
Importance of knowledge		

153

	an eye on [.] on what to look for if I kinda like go through a bad stage [.] um which I think is quite [.] grown up really to be able to kinda like go through a meeting like that and [.] be able to join in [.] so yeah	people? Scary? Important? Decisions about future? Children keeping an eye on – reversal of traditional parent child relationship. Role reversal – children as parents. What's a bad stage? Alluding to becoming unwell. Grown up – children are now adults, didn't expect them to grow up because of difficulties at home? Able to attend meetings and be helpful/understanding despite the impact on childhood? Go through a meeting like that and be able to join in – seeing as children still, implying meetings are long, difficult things for sons to hear?
Role reversal – children as parents		
	I2: So you said about um [.] that when they were about 5 you started to have some hospital admissions and that [.] you've been honest with them about things	
Information sharing changes as children get older	P2: Yeah um to a certain degree at that age 'cos you know you say basic stuff but [.] I think um rather than older children kinda like saying stuff to them about where I was [.] and what they might hear from family people [.] family members without them really knowing [..] it was just um [.] er [.] it it was hard to tell them um [.] but you just put it in basic terms on y'know [.] what was happening [.] um and then they weren't so scared about it [..] um but as they got a little bit older then they started to realise when Mum wasn't very well [...] yeah they learnt quite a lot [.] at quite young age [..] yeah	Unable to be fully honest when younger – what is basic stuff? Worried what other people might say to children about her – mad, stigma. Would children be bullied or scared about where she was? What might hear from family – family unsupportive? Earlier said were helpful. Family laughed about it or did they think she was mad? Without who really knowing – family or children? Hard to be honest with children, basic terms – was she able to tell them herself, what was it like to do this when unwell? Second person – you, when referring to self. What was happening – alluding to going into hospital, difficult to talk about? Truth/knowledge means less scared. Children realised when was unwell – what was this like for her? Pause suggests reflecting on this. Learnt a lot from young age – feels bad about this? Responsibility, grew up too quickly? Suggesting shouldn't have known about these
Stigma of mental illness		
Sharing more as children get older		
Understanding decreases fear		
Knowing a lot from a young age		

Initial grouping of Emerging Themes for participant D

1. **Cutting off to protect myself and the children: This theme illustrates how the participant feels she has to physically and emotionally hide herself away from her children as she fears that she will be unable to cope with her children's emotions as well as her own. The participant fears that her emotions will damage her children in some way and she seems to attribute this cutting off to be why she was able to keep her children. Emotions are viewed as being unsafe and damaging if they cannot be contained.**

   'I just used to shut myself away in the bathroom [..] if they were arguing I'd just shut myself in the bathroom and let them get on with it [..] I didn't wanna lose my temper with them [.] and never did [...] sort of take myself out the situation so that they couldn't see how I was [..]"

   "I didn't want them to see me worked up and upset and cryin' and [..] didn't wanna worry them [....] damaging them emotionally"

   "being mechanical really doing the things I'd gotta do but with no extra because it was just too difficult"

   - Mechanical/robotic care
   - Physically hiding away from children
   - Fear of damaging children through emotion   - UNCONTAINED?
   - Fear of showing anger
   - Anger is damaging
   - Guilt
   - Them worrying about me will damage them
   - Cutting off allowed me to keep my children

- Emotions are out of control / unsafe / damaging / confusing
- Feeling drained
- Aggravated by children – EMOTIONAL RESPONSE?
- Children raising themselves emotionally – unable to contain their emotions, led to their own difficulties
- Protecting children, trying to keep them safe but still had their own difficulties
- Detaching self
- Leaving to go into hospital – taking self away – absence
- Dependency of children is hard – both now and in the past
- Ability to cope with own and children's emotions fluctuates – unpredictability
- Putting a mask on – hiding
- Feeling a fraud, a fake, hiding emotions

2. **Being critical of my parenting, not being a good enough mum despite trying my best: This theme illustrates how the participant is critical of how she has parented her children and feels that it is her fault that they went on to have their own mental health difficulties. She compares herself to other parents and feels guilty about things she did not do with the children, such as take them to friends parties.**

"Well I feel like I failed the kids for a start [..] because they've all got problems they [.] they say they probably would've had them but [.] when they've come [.] living with me and they've turned to drugs and [..] it's my fault"

"Just because they didn't have [.] childhood like other family childhoods they didn't go to places I didn't take them out I didn't go to parties I didn't do anything [.] and they've missed out [....] they missed out when they were little"

- Growing guilt
- Comparing self to other parents
- Trying to feel as you are 'supposed' to

- What would a good parent do
- What does good mean
- Out of my control
- Children missed out on things
- Should/supposed to – critical of myself
- Blaming self for children's difficulties
- Should be able to fix children's difficulties – what a 'good' mum would do?
- Being a burden on the children
- Failure as a parent
- It's my fault
- Let children down