

Literature Review
Empirical Research Project
Reflective Commentary

Candidate number: JSNY5

University College London

Submitted in partial requirement for the Doctorate in Independent Child & Adolescent
Psychotherapy

(Independent Psychoanalytic Child & Adolescent Psychotherapy Association and
The Anna Freud National Centre for Children and Families)

Declaration

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

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

Candidate Number: JSNY5

Date: 02/05/2020

Signature: x

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Acknowledgements

I wish to acknowledge my research supervisor Michelle Slead for the consistent, steady, and reliable support that she has given me. Her positive and constructive approach has enabled me to achieve something that I thought I was far from able to do.

My research seminar leaders at the Anna Freud Centre (Michelle Slead, Nick Midgeley and Elizabeth Edington) patiently helped me to improve my understanding of qualitative and quantitative research.

My Service Supervisor, Jo Russel has given me years of support and provided me with an array of experience which has brought my academic learning to life.

The seminar leaders at IPCAPA and my intensive case supervisors (Monica Lanyado, Angela Joyce and Iris Gibbs) have helped me develop a fascination for psychoanalytic thinking and provided breadth of knowledge which sits alongside my developing understanding of research. Angela Joyce in particular ignited my interest in parent-infant psychotherapy which is at the heart of this study.

Ana Ferreira, my progress advisor, has provided endless warm and consistent support in all areas of my training.

Finally, I would also like to mention my supportive and loyal husband for being by my side throughout these years of studying. For all the words of encouragement, abundance of love, hot baths run and sacrifices that he has made.

Part 1: Literature Review

What is Known About Treatment Outcomes for Interventions That Aim to Improve Parenting or Parent-Child Relationships for Parents Diagnosed with BPD?: A Literature Review

JSNY5

Word count: 8031

Abstract

This literature review investigates the common characteristics and symptoms of people diagnosed with Borderline Personality Disorder (BPD) such as affect dysregulation, increased negative affect, difficulties employing emotional regulation, low levels of distress tolerance and interpersonal difficulties.

The impact that parents diagnosed with BPD can have on their offspring is investigated with the understanding that parents diagnosed with BPD are more likely to be associated with an unresolved/disorganized attachment style and exhibit unique parenting behaviours such as oscillations between hostile control and withdrawn behaviours, as well as oscillating between intrusiveness and overprotection.

A transmission of vulnerability is analysed as there are strong associations between maternal BPD and offspring individual BPD related symptoms and features. Further links are made to offspring behavioural problems, externalising symptoms and an increase in offspring attention deficit hyperactivity disorder.

This literature review has highlighted that whilst some attachment based and psychoeducational interventions have been adapted in order to treat parents diagnosed with BPD and their offspring, to date, there are no evidence-based treatments specifically designed for parents diagnosed BPD.

Introduction

This literature review aims to find out what is known about the treatment outcomes for mothers who have been diagnosed with borderline personality disorder (BPD) with interventions that aim to improve parenting or parent child relationships.

It is important to note that this literature review explicitly focuses on mothers as the study sample in the empirical to follow is three mothers.

Using the search terms 'BPD', 'parenting' 'mothers' and 'interventions' in databases such as PsychEd, Google Scholar and PsycInfo, a careful analysis of a wide range of relevant research and literature were undertaken and relevant references from other papers followed up.

Firstly, what is known about BPD will be explained. This will include the clinical diagnosis, common features, traits and attachment patterns exhibited by people diagnosed BPD. Relevant studies that have looked at common parenting characteristics demonstrated by parents with borderline personality disorder and their interaction and communication with their children will then be discussed. Following this, the difficulties that mothers with BPD can face whilst parenting and the possible impact this has on their offspring will be carefully considered. This will be broken down into offspring behaviour, psychopathological issues and psychosocial issues. A common characteristic of a disorganised attachment pattern will also be highlighted. Furthermore, a possible pattern of intergenerational transmission of vulnerability will be explored.

The final part of the literature review will review the literature around clinical approaches and explore treatments aimed to improve parenting or parent-child relationships for parents diagnosed with BPD. For although there are numerous effective treatments for BPD and many effective parenting treatments, this literature review will show that these two areas of interventions have not been substantially integrated and that the unique characteristics of parents with BPD have currently not been met and supported by an RCT. Whilst not negating the importance of evidence

base other than RCT's, there is a need for robust methodologies such as RCT's in this area in order to robustly evaluate the treatment aimed at supporting parents with BPD and their families.

Diagnosis

Borderline personality disorder (BPD) is a serious mental disorder that is present in 1.2 – 6 % of the population (Grant et al, 2008). The essential feature of BPD is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts (American Psychiatric Association, 2013).

The features of the condition are described as; frantic efforts to avoid real or imagined abandonment, identity disturbance, a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation, impulsiveness, recurrent suicidal or self-mutilating behaviour, affective instability due to a marked reactivity of mood, chronic feelings of emptiness, inappropriate, intense anger or difficulty controlling anger and transient, stress-related paranoid ideation or severe dissociative symptoms (American Psychiatric Association, 2013).

5 of the 9 DSM V (American Psychiatric Association, 2013) criteria listed above need to be met for a diagnosis of BPD. However, whilst some critiques have gone as far as to state the diagnosis is stigmatising and should be renamed as complex post-traumatic stress disorder (Miller, 2014), others have posed the diagnosis of personality disorder to be limiting (Widiger & Simonsen, 2005; Clark, Livesley, & Morey, 1997; Cloninger, 2000; First et al., 2002; Livesley, 2003; Rounsaville et al., 2002; Oldham & Skodol, 2000; Tyrer, 2001).

Indeed, bearing in mind that it is a descriptive diagnosis, based on appraisal of symptoms and behaviours, a wide heterogeneity of clinical presentations is to be expected. Over 200 clinical presentations are possible which casts strong doubts on the validity of such a diagnostic entity.

The categorical model for BPD reproduced in DSM-5 (American Psychiatric Association, 2013) is not empirically supported (Hopwood, Zimmermann, Pincus, & Krueger, 2015) and it is undermined by excessive comorbidity, excessive within-diagnosis heterogeneity, marked temporal instability, no clear boundary between normal and pathological personality pathology, and poor convergent and discriminant validity (Skodol, 2011; Wright & Zimmermann, 2015). BPD is therefore increasingly seen as a dimensional disorder, with emphasis on personality functioning and pathological personality traits (Skodol, 2012; Tyrer, Crawford, & Mulder, 2011).

To help make sense of this extremely complex disorder, attempts have been made to create helpful distinctions between BPD pathology. Factor analytic studies (Gunderson 2007) described three sectors of BPD psychopathology as affective, behavioural and interpersonal traits.

Features

Affective Traits

Looking more closely at affective traits, affect dysregulation is generally considered a core component of BPD (Linehan, 1993; Sanislow et al., 2002; Westen, 1991, 1998). It refers to a deficiency in the capacity to modulate emotions which can spiral out of control, change rapidly, are expressed in intense and unmodified forms, and can overwhelm reasoning. During periods of extreme stress, transient paranoid ideation or dissociative symptoms (for example depersonalization) may occur (American Psychiatric Association, 2013).

Affective instability is a dynamic, time-dependent process and because of this it is notoriously difficult to measure. Further, it is unclear how laboratory based assessments can translate into real-world experiences. However, methods to assess affect dysregulation that have used Ecological Momentary Assessment (EMA) (Stone, Shiffman, 1994; Trull Ebner-Priemer, 2009) have been able to provide multiple assessments of mood per day over many days in real life contexts. This

assessment approach yields intensive longitudinal data and is the only way to precisely assess the dynamics of mood states, extreme changes of mood, and environmental triggers for mood changes (Walls, Schafer, 2009).

The use of EMA has led to increased insight into BPD symptoms and how these symptoms are experienced in everyday life. BPD patients suffer from dramatic ups and downs in affect but only recently have the EMA empirical studies verified the ups and downs in BPD by tracking affective states over time in daily life (Ebner-Priemer et al., 2007; Links et al., 2007; Trull et al., 2008).

In addition, a number of studies have documented the centrality of negative affect to BPD (Bradley et al., 2005; Skodol et al., 2002; Trull et al., 2003; Westen et al., 1992; Zanarini et al., 1998; Zittel Conklin & Westen, 2005). In contrast to affect dysregulation, negative affect refers to a tendency to experience anxious and dysphoric affective states (Watson & Clark, 1992) rather than positive mental states. Along these lines, Carlson, Egeland, & Sroufe (2009) found, in a prospective longitudinal study of 162 individuals, that measures of negative affect in early childhood and adolescence predicted later BPD symptoms. However, often the evidence measuring negative affect is somewhat inconsistent and differences are not always significant (Henry, Mitropoulou, New, et al 2001; Trull, Solhan, Tragesser, et al., 2008).

Furthermore, individuals with BPD are less aware of their own emotions (Leible & Snell, 2004) and are less able to distinguish among emotional states, a term called emotional granularity (Barrett, 2004). A relatively recent study showed 46 individuals diagnosed with BPD showed significantly lower on measures of emotional clarity, and mood labelling arousal versus valence compared to 51 controls (Suvak et al., 2011). In a similar vein, BPD individuals were found to experience greater polarity (i.e., all-or-nothing) in their affect in an EMA study (Coifman, Berenson, Rafaeli, et al., 2012) which goes in line with the difficulty individuals with BPD in identifying and differentiating between different emotional states.

Individuals with BPD have also been found to have more problems employing emotion regulation strategies, based on both self-report and behavioural measures (Bornovalova, Gratz, Daughters, et al., 2008; Chapman, Leung, Lynch 2008; Gratz, Rosenthal, Tull, Lejuez et al., 2006) and neuroimaging studies (Koenigsberg, Fan, Ochsner et al., 2009; Schulze, Domes, Kruger, et al. 2011). Low levels of distress tolerance are also associated with BPD (Gratz et al., 2006) which suggests that those with BPD have not developed coping strategies to manage unease and distress.

Behavioural Traits

According to Lineman's (1993) biosocial theory, individuals with BPD were emotionally-sensitive children experiencing heightened negative affect and did not learn the necessary skills to regulate emotion. As a result, they have difficulties controlling what emotions they have, when they have them, and how those emotions are experienced (Gross, 1998).

Furthermore, there is a great deal of evidence that individuals with BPD engage in maladaptive regulation strategies as an attempt to reduce their negative affect when it becomes sufficiently intense. However, maladaptive cognitive strategies such as thought suppression (Cheavens, Rosenthal, Daughters, et al 2005; Rosenthal, Cheavens, Lejuez et al., 2005) and rumination (Selby, Anestis, WBender et al., 2009) have been proven to further increase negative affect. In addition, maladaptive behavioural strategies such as impulsive, suicidal and self-injurious behaviours are used with the intent to regulate affect (Klonsky, 2007).

Whilst impulsive acts are normally self-destructive such as gambling, spending money irresponsibly and engaging in substance abuse, between 50 and 90 % of individuals with BPD engage in behaviour intended to harm themselves without lethal intent such as cutting, burning and scratching (Dulit, Fyer, Leon et al; 1994 Zanarini, Frankenburg, Reich et al., 2008). Regarding suicidality, Yen et al (2002) found that affective instability, along with impulsivity and identity disturbance,

predicted suicidal behaviours. The same study concluded that childhood sexual abuse was a predictor of suicide attempts with lethal intent.

From the studies mentioned above, there seems to be a complex interplay between the different affective and behavioural features of BPD. For whilst there is an increase in emotion dysregulation and negative affect and a reduction in emotional granularity, affective difficulties are further exacerbated by the inability to employ helpful coping strategies and a lean towards maladaptive regulation strategies.

Interpersonal Traits

BPD is partly characterized by chronic instability in interpersonal relationships (American Psychiatric Association, 2013). Looking more closely at the reasons for social impairments, BPD patients have been described as highly vigilant to social stimuli. A field study revealed that social situations are potent triggers for emotional arousal and affective instability in BPD (Ebner-Priemer et al., 2007). In order to research this further, facial emotion recognition paradigms have been used to investigate the bases of interpersonal impairments in BPD, yielding mixed results. For whilst some research has found that individuals with BPD perform better than healthy controls on facial emotion recognition measures (Lynch et al. 2006; Wagner & Linehan, 1999), other studies indicate that they perform worse (Bland et al. 2004; Levine, Marziali, & Hood, 1997). It is now generally accepted that BPD patients have an enhanced sensitivity to the mental states of others (Bland, Williams, Scharer & Manning, 2004; Levine, Marziali & Hood, 1997; Minzenberg, Fan, New, et al., 2007; Guitart-Masip, Pascual, Carmona, et al., 2009) and particularly a heightened sensitivity to the detection of negative emotions (Domes, 2009) and a bias towards perceiving anger when socio-affective cues are ambiguous (Domes, 2008). Perhaps the mixed findings concerning overall accuracy in identifying emotions may be due to the different types of stimuli used in studies (e.g., social versus non-social), different instructions offered, and different emotions examined.

The heightened sensitivity to negative emotions of others and anger bias with ambiguous social cues can be linked to rejection sensitivity, i.e., the disposition to

anxiously expect, readily perceive and intensely react to rejection (Downey, Mougios, Ayduk et al., 2004). Rejection sensitivity is a trait closely related to abandonment fears and intolerance of aloneness. A study adapted the Rejection Sensitivity Questionnaire (RSQ) for application in clinical and non-clinical samples and proved to be a methodologically sound measure of rejection sensitivity. Compared to 143 clinical samples (143 patients) as well as 76 healthy controls, BPD patients scored significantly higher in rejection sensitivity from all other groups, even patients with social anxiety disorders (Staebler, Helbing, Rosenbach et al., 2011).

Extending personality research of rejection sensitivity to another clinical sample, a 21-day experience-sampling diary examined the contingent relationship between perceived rejection and rage in 45 participants diagnosed with BPD compared with 40 healthy controls (Berenson, Downey, Rafaeli et al., 2011). The indices of rejection-contingent rage were elevated in the BPD group and were strongly interrelated. This provides some evidence that reactions to perceived rejection significantly explain the rage which is often seen in BPD.

As well as a heightened sensitivity to the detection of negative emotions, an anger bias when social cues are ambiguous, rejection sensitivity and rejection rage, a further interpersonal handicap contributing to the likelihood that BPD patients have disturbed relationships are failures in mentalization. Mentalization is the capacity to make sense of self and of others in terms of subjective states and mental processes (Fonagy & Bateman, 2006). In fact, recent evidence suggests that individuals with BPD show a tendency toward hypermentalization, that is, the overinterpretation or over attribution of overly complex intentions or mental states, leading to inaccuracies and confusion between the mental states of self and others (Sharp et al., 2011, 2013).

Such inaccuracies and confusion of mental states and the consequent re-emergence of more primitive mental states is the core psychological difficulty of patients with BPD which unfortunately has a profoundly damaging effect on helping to create, maintain and develop healthy interpersonal relationships (Gunderson 2007).

Attachment and BPD

Difficulties with attachment are considered by some to be at the heart of BPD (Levy, 2005). In fact, attachment difficulties have been noted in many studies of individuals with BPD, and that is why attachment theory is so relevant.

The affective bond that develops between an infant and their caregiver is the developmental nucleus of identity formation, intrapersonal regulation, and interpersonal attitudes (Bowlby, 1973, 1977). A secure attachment is formed when a reliable and sensitive caregiver meets an infant's biological and psychological needs. The infant is able to turn to their caregiver when experiencing distress, fear, or other needs and has a sense that the caregiver is looking out for them (a secure base). However, if the infant's needs are not met by a caregiver, then the attachment is disrupted.

Ainsworth et al. (1978) adapted Bowlby's conceptualisation of attachment and noted three major attachment styles: secure, anxious-ambivalent, and avoidant. A fourth attachment style – disorganized/unresolved was later added by Main and Solomon (1986, 1990). In a meta-analysis of studies investigating infant attachment which included over 2,000 infants studied by multiple research groups, these same four categories of attachment behaviour were found (van IJzendoorn & Kroonenberg, 1988). Furthermore, these styles have been directly linked to differences in caregiver warmth and responsiveness (van IJzendoorn, 1995).

Whilst secure adults value attachment relationships and seem to be able to deal effectively with potentially invasive or negative feelings about the past or future, this is not the case with individuals with BPD. Supporting this, a large body of empirical research has revealed the theoretical connection between attachment insecurity and personality pathology (Levy, 2005; Nakash-Eisikovits et al 2002; Clarkin, Fonagy & Gabbard 2010).

Similar to the variety and complexity of BPD features, there is no one size that fits all for the styles of attachment. Individuals may show traits of a combination of few attachment styles and others may sit in one attachment style category only.

Unresolved/disorganized attachment style is strongly associated with BPD. Bakermans-Kranenburg and van IJzendoorn (2009) confirmed these findings in a meta-analysis of adult attachment distributions in clinical samples. Whilst some commentators state that the contradictory and fragmented internal working models associated with unresolved attachment may be consistent with the unstable sense of self and others characteristic of BPD (Liotti, 2000), others link disorganized attachment to early childhood and state that disorganised characteristics early on may directly contribute to a later diagnosis of BPD (Fonagy, Gergely, Jurist et al., 2002). It has been suggested that an insecure attachment formation in childhood, often resulting from traumatic experiences that are common in BPD, leads to problems with identity formation and difficulties with emotion regulation (Fonagy et al., 2011).

Attachment anxiety and BPD have been linked (Levy, 2005). Furthermore, the relation between preoccupied attachment and BPD appears to be mediated by anger, irritability, and social dysfunction (Critchfield, Levy, Clarkin et al., 2008; Morse et al., 2009).

Whereas the association between avoidance and BPD is less consistent, with some studies finding no relationship between these constructs (e.g., Meyer, Pilkonis, & Beevers, 2004), other research has shown correlations between attachment avoidance and BPD when anxiety was also high (Levy, Meehan, Weber, et al., 2005) for example through self-harm (Critchfield et al., 2008). This suggests that fearful attachment may contribute to BPD.

Parenting Characteristics and Mother-Infant Interaction and Communication

BPD poses significant challenges for parents when they attempt to establish a relationship with their infant. For parents with a background of unresolved attachment related trauma, the relationship with their infant is simultaneously an opportunity for a reworking of their own background but also brings risk of traumatic and dysfunctional dynamics.

Unfortunately, parenting in the context of BPD is not well understood but there has been a generous amount of research in this area varying in type and size of studies. Accepting some inconsistencies across studies, mothers with BPD symptoms have commonly shown a number of characteristics within the mother-infant dyad which is worth mentioning.

Interaction Style

There have been some very interesting recent findings with mother-child interactions. Three studies reported that mothers with BPD had significantly less “satisfying/engaged,” or more “difficult” or “dysfunctional” mother-child interactions according to observation (Crandell et al., 2003; Newman et al., 2007) and maternal self-report (Elliot et al., 2014) in comparison to healthy controls. In addition, mothers with BPD showed significantly less imitation, less smiling, touching, and playing with their infants than healthy controls (White, Flanagan, Martin et al., 2011). Furthermore, Hobson et al. (2009) found that mothers with BPD displayed significantly greater “frightened/disoriented” (i.e., fearful, hesitant) interaction with their infants than mothers with depression or healthy controls.

Mothers with BPD have been shown to be less sensitive/have lower “non-intrusive sensitivity” with their infants compared to healthy control mothers (Crandell et al., 2003; Newman, Stevenson, Bergman, et al., 2007) with a significantly higher “intrusive in-sensitivity” towards their infants (Hobson, Patrick, Crandell, et al., 2005). In fact, Hobson et al. (2009) found that mothers with BPD symptoms were

significantly more “insensitive” with their infants when infant distress persisted for longer durations.

Studies have indicated that mothers with BPD are more protective (or overinvolved) with their offspring than their controls. Through self-reported overprotection (Elliot et al. 2014) and adolescents reporting of the overprotection of their mothers’ who have been diagnosed with BPD (Reinelt et al. 2014; Barnow et al. 2006). Maternal BPD symptoms were also significantly positively correlated with offspring-reported maternal attempts to “control through guilt” and negatively correlated with “acceptance of individuation.” (Zalewski et al. 2014). On the other hand, one study assessed maternal laxness and found that maternal BPD symptoms were positively associated with maternal self-reported laxness (Harvey et al. 2011).

However, in terms of hostile behaviour towards their infants, Elliot et al. (2014) found that BPD symptom severity was significantly positively correlated with raised levels of maternal hostile/reactive behaviours and furthermore, mothers with BPD scored significantly higher than healthy controls on the “hostility” of a general psychopathology measure (Newman et al 2007).

In addition, a significant correlation between maternal BPD symptoms and displays of “negative affect” (i.e., irritability, annoyance, frustration, anger) and between maternal BPD symptoms and self-reported “over reactivity” (i.e., noticeably frustrated or angry) was found (Harvey et al. 2011). Similarly, with adolescent offspring, maternal BPD (Frankel-Waldheter, Macfie, Strimpfel et al., 2015) and maternal BPD symptoms (Herr et al., 2008) were significantly associated with offspring-perceived “maternal hostility” (Herr et al., 2008), and researcher-observed (Frankel-Waldheter et al., 2015) “maternal hostility”.

When considering these last characteristics, it is interesting to note that mothers with BPD may demonstrate a confusing medley of inconsistent parenting characterised by over-involvement such as overprotection and inhibiting autonomy on the one hand, and disengagement, laxness and hostility on the other.

Studies conflicted in their findings of BPD maternal rejection for whilst one study found that mothers with BPD did not significantly differ in adolescent offspring-perceived “rejection” from mothers with depression, cluster C personality disorders, or no mental health condition (Barnow et al. 2006), a further study reported a significant positive correlation between maternal BPD symptoms and adolescent-perceived maternal rejection (Reinelt et al. 2014).

Emotional Recognition

To date, two studies have assessed emotional recognition of mothers with BPD. One found that mothers with BPD were significantly poorer than healthy controls at “infant emotion recognition.” In particular, neutral infant expressions were more often perceived as sad (Elliot et al., 2014). Another study looked at discrepancies between mother-reported and researcher observed infant expressions (Whalen, Kiel, Tull, et al., 2015). Findings showed that as maternal BPD symptom severity increased, there was greater convergence between mother-reported and observed infant anger. This relationship increased in strength as observed infant anger increased. The authors suggested that mothers with BPD may have heightened sensitivity to infant anger, in a similar vein to the anger bias as previously discussed (Downey, Mougios, Ayduk, et al., 2004).

Communication

With mother-infant communication between BPD mothers and their offspring, studies have yielded very mixed results. Whilst some research reported that mothers with BPD did not significantly differ from mothers with depression or healthy controls in “vocalisations” (i.e., percentage of time spent vocalising) when interacting with their infants (Hobson et al., 2009; White et al., 2011), another study found no significant difference in overall frequency of vocalisations compared to healthy controls (Delavenne et al. 2008). In contrast to these findings, Hobson et al. (2009) found that mothers with BPD displayed significantly greater “disruptive affective communication” (i.e., conflicting emotional cues, unresponsive to infant emotion) in interactions with their infants in comparison to depressed and healthy controls.

It is important to note that in the findings regarding BPD and parenting, only a small number of studies have included both non-clinical controls and controls with another diagnosis. Although parents with BPD consistently show difficulties compared to healthy controls, it is important to compare results with parents who have a variety of other psychopathologies and stressors in order to gain a broader and deeper analysis of BPD parenting behaviour.

From carefully looking at BPD parenting characteristics listed above, a pattern of both laxness (Harvey et al. 2011) and under involvement (White et al., 2011) on the one hand, and intrusiveness (Hobson et al., 2005) and over-involvement (Reinelt et al. 2014; Barnow et al. 2006) can clearly be observed. Findings have not suggested that these mothers lack a desire to care for their child. Indeed, studies measuring overprotection found that mothers reported a concern for their child's health and safety (Elliot et al., 2014; Reinelt et al., 2014; Zalewski et al., 2014). The parenting stress and lack of efficacy that mothers with such a complex disorder have reported (Elliot et al., 2014; Newman et al., 2007) further highlights the challenges that characterise their patterns of parenting and mother-offspring interactions.

Parents' Diagnosed with BPD Own Views of Parenting

Although there are only a handful of studies examining the perceptions of parenting from point of views of individuals with BPD, one piece of research found that mothers with BPD reported being more distressed, less satisfied, and less competent in their parenting roles (Newman et al., 2007).

More recently, a small qualitative study of 23 mothers diagnosed with BPD, shared their concerns in focus groups about the challenges they feel they face in parenting. The most prominent thread throughout all the interviews was mothers' worry, guilt, and uncertainty around the parenting role and further showed intense guilt about trying to parent with mental health issues. (Zalewski, Stepp, & Whalen et al., 2015). These findings are consistent with those reported by Newman and colleagues (2007), who found that mothers with BPD expressed less satisfaction and confidence

and reported more distress about their parenting compared with mothers without BPD.

Impact of Parental BPD on Children

It is important to keep in mind other factors which may affect the children's functioning such as genetic factors, socio-economic factors and/or parental break ups. However, a great number of studies have shown an association between mothers diagnosed with BPD and aspects of poor functioning of their children in many areas such as behaviour, psychopathological issues (i.e., BPD and BPD symptoms, depression, internalising and externalising problems) and psychosocial issues (i.e., self-esteem difficulties, interpersonal difficulties, home difficulties and stability).

In addition, a disorganised attachment pattern is heavily associated with maternal BPD or BPD symptoms in offspring infancy (Gratz et al., 2014; Hobson et al., 2005), childhood and adolescence (Abela et al., 2005) and adolescence (Herr et al., 2008). This type of attachment pattern is likely to affect all other outcomes discussed below.

Infant Behaviour

Infants and toddlers of mothers with BPD can behave very differently to healthy controls. For instance, although including only a small sample size of eight mothers with BPD and twelve mothers without a psychiatric disorder, Crandell et al. (2003) undertook a study called the 'still-face' challenge, a piece of research that assessed mother-infant interaction using a camera to videotape each dyad interact within three distinct phases. Firstly, by recording two minutes of face to face play, followed by a second period where the mother maintained eye contact with their infant but remain silent and kept a still face before finally the mother-infant dyad were recorded engaging in face to face play again.

The authors found that when exposed to a 'still-face' challenge, 2-month-old infants of mothers with BPD were more likely to look away, show less positive affect or to look dazed than children of healthy controls.

In other studies of face-to-face interactions between mothers and their infants, children of mothers with BPD were shown to smile less (White et al., 2011), vocalise less (White et al., 2011; Delavenne, Gratier, Devouche, et al. 2008) avert their gaze more, appear more fearful and be less soothable (White et al. 2011), be less responsive to mothers' bids for interaction, and show less optimally 'involving' behaviours towards their mothers than control babies (Newman & Stevenson, 2008.) They also displayed lower 'availability for positive engagement' with their mothers, showed fewer positive looks towards a stranger, and had lower 'behavioural organisation' and mood state (Hobson et al. 2005).

Psychopathological Issues

A significant association between maternal BPD and subsequent offspring BPD symptoms has been found (Barnow et al., 2013; Cheng et al., 2011; Conway, Hammen, & Brennan, 2015; Stepp, Olino, Klein, Seeley et al., 2013). In a community-based study, Barnow et al. (2013) found that maternal BPD symptoms predicted offspring BPD symptoms five years later (at age 20) and in a high-risk community cohort spanning 4 time-points (14, 18, 24 & 30 years of age), Stepp et al. (2013) found that maternal history of BPD predicted offspring BPD symptoms at age 30.

Furthermore, a number of studies have assessed associations between maternal BPD and offspring individual BPD related symptoms and features which have a strong association with BPD, such as insecure attachment. For example, some studies suggest that maternal borderline personality pathology is significantly associated with offspring emotional dysregulation across age groups operationalised in various ways such as; "low soothability" in infancy (White et al., 2011); "boundary confusion between self/fantasy or reality/fantasy" (Macfie & Swan, 2009) and "self-

regulation” (Macfie et al., 2014) in childhood were all significantly associated with maternal BPD.

In terms of examining aspects of offspring's self-identity, Macfie et al. (2009) reported that children of mothers with BPD had significantly poorer self-representations (incongruent and shameful) than children of healthy controls. A study examining gender identity disorder (GID) found that mothers of boys with GID were found to be significantly more likely to have a diagnosis of BPD than mothers of boys without GID (Marantz and Coates, 1991).

Children of mothers with BPD reported significantly more suicide ideation and death wishes, and more suicide attempts (Barnow et al., 2006) to healthy controls, although interestingly there was no significant difference with actual suicide attempts. Furthermore, studies have indicated that children and adolescents of mothers with BPD are at greater risk of developing depression (Abela et al., 2005; Barnow et al., 2006; Herr et al., 2008). However, the extent to which this association is independent of maternal depression continues to remain unclear.

When internalising and emotional problems are taken into account, offspring of mothers with BPD were found to have significantly increased “emotional problems” in adolescents compared to adolescents of mothers with depression or no psychopathology (Barnow et al., 2006). In contrast, Bertino, Connell, and Lewis (2012) found no significant association between parental borderline traits and offspring “internalising” problems. This study, however, only had a small sample size.

Many studies have indicated that the offspring of mothers with BPD are at an increased risk of behavioural problems or externalising symptoms. For instance, Barnow et al. (2006) reported significantly more aggression, attention and delinquency problems in adolescents of mothers with BPD in comparison to adolescents of healthy controls. Bertino et al. (2012) found a notable positive correlation between maternal borderline personality symptoms and both child and adolescent externalising symptoms. Furthermore, significantly more cases of attention deficit hyperactivity disorder and disruptive behaviour disorder was reported

in children of mothers with BPD in comparison to children of mothers with other personality disorders (Weiss et al. 1996).

Psychosocial Issues

Studies looking at offspring self-esteem difficulties had mixed results. For whilst one study found significantly lower levels of self-esteem in adolescents of mothers with BPD compared to children of mothers with depression, Cluster C personality disorders, or no mental health condition (Barnow et al. (2006), a further study found that although maternal BPD and maternal depression was significantly associated with offspring self-criticism, this was not the case with offspring self-esteem in children and adolescents of mothers with BPD (Abela et al., 2005). It is curious why these results seem to differ. However, what is interestingly highlighted by Barnow et al. (2006) is that mothers with depression have more of a negative effect on their offspring's self-esteem than mothers diagnosed with BPD.

The offspring of mothers with BPD have difficulties with mental state understanding and social interactions and three studies have demonstrated this. Schacht et al. (2013) found that children of mothers with BPD demonstrated significantly poorer emotional labelling and understanding of causes of emotion in comparison to the offspring of healthy controls. In addition, scores on the social problem scale were found to be significantly elevated in adolescents of mothers with a BPD diagnosis in comparison to adolescents of mothers with, cluster C personality disorders, depressive disorder or no mental health condition (Barnow et al., 2006). Furthermore, maternal BPD symptoms remained significantly associated with adolescent offspring's poor self-perception of the ability to make "close friendships" and be "socially accepted," even after controlling for maternal depression (Herr et al., 2008).

Studies have shown some evidence that family dynamics and home life are affected in the families of mothers with BPD. Whilst mothers with BPD reported significantly lower family "cohesion" and "organisation" than mothers with other personality disorders (Feldman et al., 1995), children and adolescents of mothers with BPD

experienced significantly greater instability, such as frequent changes in school and household composition, than offspring of mothers with other personality disorders (Feldman et al., 1995). Furthermore, after controlling for maternal depression, both adolescent-reported “family stress” and mother-reported “chronic relationship stress” were significantly correlated with maternal BPD symptoms in a community sample (Herr et al., 2008). The offspring of mothers with BPD were also significantly more likely to witness maternal or paternal suicide attempts and be exposed to parental alcohol/drug abuse (Feldman et al., 1995).

Potential Reasons for the Transmission of Vulnerability

Studies in transgenerational aetiological vulnerabilities are rare. Furthermore, most studies are cross-sectional in nature and cannot take into account intra individual development over time making it difficult to draw conclusions regarding temporal precedence and aetiological mechanisms.

However, it is now believed (Reinelt et al., 2014; George, Kaplan, & Main, 1984; (Macfie et al., 2014; Gratz et al., 2014) that the transmission of a range of difficulties and vulnerabilities from a parent diagnosed with BPD to their child can occur. It therefore seems pertinent to look more closely at how and why this transmission of vulnerability may occur from one generation to the next.

Parent-child Interactions, Associated Attachment Patterns and Trauma

Reinelt et al. (2014) showed in a study that some BPD symptoms were transmitted longitudinally from mother to adolescent. Maladaptive mother–child interactions were represented by a latent variable comprising of a perceived overprotective and rejecting parenting style and high mother–child discrepancies regarding child's internalising problems. The authors also made a connection with the relationship between maternal BPD and offspring individual symptoms of impulsiveness, difficulties identifying and describing feelings, and self- esteem.

Maternal emotional dysfunction was looked as a mediator by Gratz et al. (2014) who reported a significant indirect association between clinically relevant levels of maternal BPD symptoms and infant emotional regulation difficulties via maternal emotional dysfunction. Put more simply, mothers with BPD were more likely to experience emotional dysfunction, which in turn increased the risk of infant emotional dysregulation. Furthermore, maternal emotional intensity/reactivity facilitated an indirect effect of maternal BPD symptoms on lowering the ability for infants to self-regulate but this was only in infants with an insecure-resistant attachment relationship.

Although there has not been a study to date measuring the intergenerational transmission of attachment patterns of both parents with BPD and their children, a pattern of disorganised attachment patterns in mothers with BPD has been highlighted (Bakermans-Kranenburg and van IJzendoorn 2009). This is likely to lead to disrupted behavioural interactions between themselves and their infants which in turn may lead to poor outcomes for children of parents with BPD.

Several retrospective (Battle et al., 2004; Zanarini, 2000) and prospective studies have confirmed that childhood adversity is highly predictive of later onset of BPD. For example, the New York longitudinal study found that BPD was associated with low levels of parental affection and nurturing, and with aversive parental behaviours, such as harsh punishment (Johnson, Cohen, Chen, Kasen, & Brook, 2006). A smaller prospective study reported that disrupted maternal communication in infancy and later experiences of abuse in adolescence contributed to the prediction of symptoms of borderline pathology at age 18 (Lyons-Ruth, Yellin, Melnick, & Atwood, 2005).

A further study (Crawford, Cohen, Chen, Anglin, & Ehrensaft, 2009) followed up individuals from adolescence and found that symptoms of BPD declined with age, but the rate of decline was moderated by experience of early maternal separation, with individuals separated before the age of 5 showing slower rates of decline. Finally, a large prospective study, investigating the association between maladaptive

parenting and BPD symptoms at age 11, found that family adversity predicted BPD pathology (Winsper, Zanarini, & Wolke, 2012)

Treatment Interventions for Parents Diagnosed with BPD

Although there are numerous effective treatments for BPD (Leichsenring, Leibing, Kruse, New, & Leweke, 2011; Bateman & Fonagy P. 2004, 2006), and many effective parenting treatments (Cedar & Levant, 1990; de Graaf, Speetjens, Smit, de Wolff, & Tavecchio, 2008; MacKenzie, Fite, & Bates, 2004), these two areas of intervention have not been substantially integrated. Indeed, there is one treatment aimed for parents who are diagnosed with BPD called Parenting Skills for Mothers with Borderline Personality Disorder (Rennenberg & Rosenbach, 2016) which has a cognitive and DBT approach. It is a manualised intervention and uses validated measures such as BSI, Beck Depression Inventory.

Other than this treatment, adapted attachment based and psychoeducation interventions have, to date, been the main types of treatment used for mothers with BPD.

Attachment Based Interventions

Attachment based interventions strive to hinder the transmission of insecure and/or disorganized attachments from a parent (usually the mother) to their offspring. This is undertaken in either individual psychotherapy with the mother as the primary patient or psychotherapy with the mother-infant dyad.

Individual psychotherapy with the parent aims to provide a corrective attachment experience through interaction and experiences with the therapist (Lieberman, Weston and Pawl 1991; Lieberman and Zeanah, 1999). In addition, the parent is encouraged to think and talk about their own childhood experiences and link them to their current relationship with their child with the hope of gaining some insight into how the cycle of insecure and/or disorganised attachment might be perpetuated.

Unfortunately, this type of therapy has not been well manualised which has impeded dissemination and evaluation efforts.

A Psychoanalytic approach comes under the realms of attachment based psychotherapy. However, in a psychoanalytic approach, the therapist aims to bring the unconscious into awareness to bring about change. For example, Fraiberg et al. (1975) described the ghosts in the nursery as the unresolved issues in the mind of the parent. For parents with BPD this is a particularly potent dynamic, and within this framework interventions aim at freeing the infant from the network of unresolved parental trauma allowing them to follow their own developmental agenda.

With psychotherapy that includes the mother-infant dyad in the sessions, the therapist observes the interaction between the mother and child. The observations are used to help the mother link her past experiences and own attachment style to her current relationship with her child. Questions may be asked such as; “who is the infant in the mind of the parent?”. (Biseo et. al, 2016)

Psychoanalytic Parent-infant psychotherapy (PIP Fonagy, Sled & Baradon, 2016) also focuses on supporting the parent in the development of reflective capacity. Parental reflective functioning refers to the parent’s capacity to understand herself, her infant and their interaction in relation to their mental states. Parental reflective functioning gives the parent the ability to focus on the infant as separate from herself, with his/her own psychological needs (Fonagy et. al, 1991).

There are several manualised types of PIP which have been used to treat parents with serious mental health disorders and their children. They have been adapted for use with mothers diagnosed with BPD but there are specifically designed treatments to date.

The interventions include Watch, Wait, Wonder (WWW; Muir, Lojkasek, & Cohen, 1999); PIP and toddler-parent psychotherapy e.g. Chicchetti, Rogosch, & Toth, 2000); Circle of Security (COS; Marvin, Cooper, Hoffman & Powell 2002); Minding the Baby (Slade 2007); and Parenting With Feeling Infant-Parent Intervention

Program (Newman 2015). Each intervention varies as to how much psychoeducation and parent training are included with some treatment types such as WWW including no psychoeducation at all.

Mentalization-based treatment (MBT) is now an evidence based approach for working with people diagnosed with BPD (Bateman & Fonagy 2004, 2006). However, although it has been adapted to work with mothers diagnosed with BPD, the effectiveness of the adapted treatment has not been supported by an RCT.

To date, there has been a lack of robust evaluation of the effectiveness of treatments aimed specifically to support mothers with BPD and their infants. For instance, Newman and Stevenson (2008) used WWW with 20 mothers diagnosed with BPD. However, not only did the study have a very small sample size but additionally, the measures did not evaluate the treatments effectiveness in improving mother-infant relationships.

Effectiveness of Attachment Interventions

Results measuring the efficacy of attachment interventions are mixed (Lieberman & Zeanah, 1999). This could be due to the variability in techniques employed across different attachment interventions which could impede researchers' ability to demonstrate their effectiveness.

Findings from a meta-analysis of attachment-based interventions showed that while they helped increase maternal sensitivity towards their infants and children, the treatments had little impact on the attachment security of the parent and child (Van Ijzendoorn, Juffer, and Duyvesteyn, 1995).

However, more recently, attempts have been made to manualise attachment based interventions which has resulted in more evidence supporting their effectiveness and improving attachment security and/or attachment organization in children (Cicchetti et al., 1999; Toth et al., 2002; Hoffman et al., 2006; Marvin et al., 2002; Cohen et al., 2005).

However, even though attachment-based interventions are becoming codified and the effectiveness of the treatments for high risk mother-infant dyads is being proven, the utility of these interventions when offered alone for mothers with BPD and their children may be compromised. For instance, a systematic review of PIP (Barlow et al., 2015) suggested that in high-risk families, there were no significant differences compared with no treatment or treatment-as-usual for other parent-based or relationship-based outcomes, and no evidence that PIP is more effective than other methods of working with parents and infants.

To help explain this, there appears to be a gap between the goals of mothers with BPD when they seek professional help and the objectives of attachment-based interventions (Conroy et al., 2009; Newman et al., 2007). Attachment-based interventions applied without any focus on parenting skills are unlikely to alleviate the overbearing distress and concerns they have for providing the basic needs for their children (Stepp et al., 2012). It therefore seems that mothers with BPD may require parent skills training and psychoeducation before addressing parent–infant attachment strategies.

Psychoeducational Interventions

Psychoeducational interventions primarily provide information on a variety of relevant issues to family members of the afflicted rather than solely working with the parent or parent/infant dyad. Furthermore, the impact of family psychoeducation interventions on parents with BPD has lagged behind other serious mental illnesses. Gunderson and colleagues (1997) have long since advocated for a manualised family psychoeducational approach to the treatment of BPD but unfortunately to date, no psychoeducational treatments have been designed specifically for parents with BPD.

To date, there are three types of psychoeducation treatment models which have been adapted for the use with families who have a family member with BPD. These are Family Connections (FC; Fruzzetti & Hoffman, 2004) which focusses exclusively on family psychoeducation, Systems Training for Emotional Predictability and

Problem Solving (STEPPS; Blum, Pfohl, St John, Monahan, & Black, 2002) and multigroup family skills training (Miller, Rathus, & Lineman, 2006). STEPPS and multigroup family skills training are understood to improve the outcomes for patients diagnosed with BPD whereas FC is understood to relieve caregiver stress (Stepp et al., 2012). However, limitations lie in the lack of randomised control trials available to assess treatment outcomes for these adapted interventions for parents with BPD.

Effectiveness of Psychoeducational Interventions

To date, there have been no RCT's examining the impact of family psychoeducational approaches on both BPD parent outcomes. A brief intervention was piloted specifically to support parents with BPD which included interventions designed to protect children from the extremes of the disorder and support with both parenting skills and healthy child development (McCarthy et al., 2016). However, there were many limitations to the study. For instance, only the clinicians' views were considered when measuring the effectiveness of the intervention and a control group was not included.

Furthermore, a systematic review (Barlow, J., et al., 2012) of group based parent training programs (not specifically designed for parents with BPD) showed only short term improvements in depression, confidence, stress and anger but none of these improvements were significant after one year.

Further Thoughts about Interventions for Parents Diagnosed with BPD

Behavioural parent training and emotion regulation skills that are in sync with components of dialectical behaviour therapy (DBT) have been seen as a preferable form of treatment for parents with BPD (Zalewski and Lengua, 2011). However, there is no RCT to support this view.

Fruzzetti (2011) highlights the importance of brief, focused interventions with this population because of their high levels of distress. Macfie (2011) posits that parents diagnosed with BPD may have difficulty learning new parenting skills while still

experiencing symptoms. Furthermore, Newman, Stevenson, Bergman, & Boyce (2007) state that solely targeting parenting skills may be particularly helpful in reducing symptoms, as these parents experience extremely high rates of distress specifically around issues related to parenting and the parent–child relationships.

Conclusions

As researched methods have improved over the years, there has been an increased insight into the characteristics of people diagnosed with BPD and their symptoms. Common affective traits for people diagnosed with BPD can now be more accurately measured (Stone et al. 1994; Trull et al., 2009) and include characteristics such as affect dysregulation (Linehan, 1993; Sanislow et al., 2002; Westen, 1991, 1998), increased negative affect (Bradley et al., 2005; Skodol et al., 2002; Trull et al., 2003; Westen et al., 1992; Zanarini et al., 1998; Zittel et al., 2005), difficulties employing emotional regulation (Bornovalova et al., 2008; Chapman et al., 2008; Gratz et al., 2006), and low levels of distress tolerance (Gratz et al., 2006).

Maladaptive coping strategies such as thought suppression (Cheavens et al., 2005; Rosenthal et al., 2005), rumination (Selby et al., 2009), impulsive behaviour, suicidal and self-injurious behaviour (Dulit et al; 1994 Zanarini et al., 2008) can be used with the intent to regulate affect (Klonsky, 2007).

In terms of common interpersonal traits, it is now believed that people diagnosed with BPD can have an enhanced sensitivity to the mental states of others (Bland et al., 2004; Levine et al., 1997; Minzenberg et al., 2007; Guitart-Masip et al., 2009), a heightened sensitivity to negative emotions (Downey et al., 2004), an anger bias related to perceived rejection (Berenson et al., 2011), and inaccuracies and confusion between the mental states of self and others (Sharp et al., 2011, 2013). These common characteristics profoundly damage the capacity to make and develop healthy interpersonal relationships (Gunderson 2007).

Parents diagnosed with BPD have shown to express elevated worry, guilt, and uncertainty around the parenting role (Zalewski, et al., 2015). They have further shown to have unique parenting behaviours such as oscillations between hostile control (Barnow et al. 2006) and withdrawn behaviours (Zalewski et al. 2014; Harvey et al. 2011), as well as oscillating between intrusiveness/overprotection (Reinelt et al. 2014) and hostility (Herr et al., 2008; Frankel-Waldheter et al., 2015).

In addition, unresolved/disorganized attachment style is strongly associated with BPD (Bakermans-Kranenburg et al., 2009) and it is now believed that parents diagnosed with BPD can have a negative affect on their children's behaviour (White et al., 2011; Delavenne A, et al., 2008; Newman et al, 2008; Hobson et al. 2005), their psychopathology (Barnow et al., 2013; Cheng et al., 2011; Conway et al., 2015; Stepp et al., 2013) and can affect their children's psychosocial functioning (Barnow et al. 2006; Abela 2005; Schacht et al., 2013; Herr et al., 2008; Feldman et al., 1995).

A cycle of vulnerability has been detected where a transmission of a range of difficulties and vulnerabilities from a parent diagnosed with BPD to their child can occur (Reinelt et al., 2014; George et al., 1984; Macfie et al., 2014; Gratz et al., 2014). This can include the intergeneration transmission of the traits associated with a disorganised attachment pattern (Fonagy et al., 2002; White et al., 2011).

This literature review has highlighted a lack of RCT's to measure the treatment outcomes specifically for parents with BPD and their children. There have been suggestions aimed at supporting parents diagnosed with BPD to help reduce symptoms such as a DBT approach (Zalewski et al., 2011), brief focused interventions (Fruzzetti, 2011; Mackfie 2011), or solely targeting parenting skills (Newman et. al, 2007). Beyond these suggestions, the research shows that there are two main strands of interventions – psychoeducational and attachment based. However, to date, there are no treatments within these strands of intervention that have been specifically designed for mothers diagnosed with BPD.

Some psychoeducational programs have been altered to treat mothers diagnosed with BPD such as FC (Fruzzetti et al., 2004), STEPPS (Blum, et. al, 2002) and multigroup family skills training (Miller, et al., 2006) but their outcomes for mothers diagnosed with BPD is not evidence-based.

Similarly attachment based interventions such as WWW (Muir et al., 1999); PIP (Fonagy et al., 2016), toddler-parent psychotherapy (Chicchetti et al., 2000); COS (Marvin, et al., 2002); Minding the Baby (Slade 2007); and Parenting With Feeling Infant-Parent Intervention Program (Newman 2015) have been adapted to treat mothers diagnosed with BPD and their children but similar to psychoeducational programs, their effectiveness is not supported by an RCT.

Attachment-based interventions have shown some evidence of effectiveness of improving attachment security and/or attachment organization in parents and children (Cicchetti et al., 1999; Toth et al., 2002; Hoffman et al., 2006; Marvin et al., 2002; Cohen et al., 2005). However, it is unknown whether attachment based interventions, when offered alone without any psychoeducational input for mothers diagnosed with BPD, are effective.

Related to this, a discrepancy is believed to exist between the goals of mothers with BPD when they seek professional help and the objectives of attachment-based interventions (Conroy et al., 2009; Newman et al., 2007). Furthermore, Stepp et al. (2012) argue that attachment-based interventions applied without any psychoeducational input are unlikely to alleviate the overbearing distress and concerns that parents diagnosed with BPD may have for providing the basic needs for their children.

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Part 2: Empirical Research Project

How do mothers with BPD traits experience changes in their relationship with their infants after engaging in an attachment focussed PIP?

JSNY5

Word count: 8515

Abstract

This study investigates how three participants with traits of Borderline Personality Disorder (BPD) experience changes in their relationship with their infants after engaging in an attachment focussed parent-infant psychotherapy (PIP). It is a sub-study of a wider Randomized Control Trial (RCT) which investigated the outcomes of PIP for parents with mental health problems and their young infants (Fonagy, Slead & Baradon, 2016).

Data was based on a semi-structured interview and subjected to Interpretative Phenomenological Analysis (IPA, Smith 1995, 1996) providing a qualitative perspective to get closer to the lived experience of the three participants. The themes that emerged were separated into improvements in the parent-infant relationship, and continued difficulties in the parent-infant relationship.

The data illustrates the factors which supported two participants to experience positive changes between themselves and their infants which were namely; medication changes, support from an inpatient unit, time, praise from others, the ability to locate the source of change within themselves and the PIP sessions. Results in this theme varied for whilst the participant who had the most PIP sessions was able to see some positive changes in how she related to her baby, the participant with the least PIP sessions was able to describe the most positive change in her relationship with her infant.

Failures in mentalization (Fonagy & Bateman, 2007), low levels of distress tolerance, poor coping strategies to manage distress, a sense of helplessness and isolation, interpersonal difficulties, continued mental health difficulties and an inability to locate the source of change within themselves are shown to stand as some obstacles for participants to experience changes in the relationship with their infants.

Impact Statement

This empirical study addresses how mothers with borderline traits interact with their infants after engaging in an attachment focussed PIP intervention. It looks at the improvements in the parent-child relationship and continued difficulties. The research shows that one of the three participants made very few improvements in the way that she interacted with her child after engaging in an attachment focussed PIP and the participant who made the most change had the least amount of PIP sessions. It is therefore questionable whether a purely attachment focussed treatment for mothers with BPD traits is an affective choice of treatment.

This research has shown that there is one manualised treatment designed to help parents with BPD relate to their offspring. Despite having some validated measures, its effectiveness is not supported by an RCT.

Further manualised and robustly measured treatments specifically designed for parents diagnosed with BPD would have an enormous positive impact for parents, infants and families who are affected by BPD and would hope to hinder the transmission of vulnerability between generations.

Introduction

What is BPD?

Borderline personality disorder (BPD) is a serious mental disorder that is present in 1.2 – 6 % of the population (Grant et al, 2008). The essential feature of BPD is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts (American Psychiatric Association, 2013).

The features of the condition are described as; frantic efforts to avoid real or imagined abandonment, identity disturbance, a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation, impulsiveness, recurrent suicidal or self-mutilating behaviour, affective instability due to a marked reactivity of mood, chronic feelings of emptiness, inappropriate, intense anger or difficulty controlling anger and transient, stress-related paranoid ideation or severe dissociative symptoms (American Psychiatric Association, 2013).

Five of the nine DSM V (American Psychiatric Association, 2013) criteria listed above need to be met for a diagnosis of BPD.

BPD poses significant challenges for parents when they attempt to establish a relationship with their infant. For parents with a background of unresolved attachment related trauma, the relationship with their infant is simultaneously an opportunity for a reworking of their own background but also brings risk of traumatic and dysfunctional dynamics.

Those diagnosed with BPD characteristics have previously been characterised as having a limited capacity to make sense of self and of others in terms of subjective states and mental processes, a process named mentalization (Fonagy & Bateman, 2007). More recent evidence suggests that individuals with BPD actually show a tendency toward hypermentalization. That is the over interpretation or over attribution of overly complex intentions or mental states, leading to inaccuracies and confusion between the mental states of self and others (Sharp et al., 2011, 2013).

Such inaccuracies and confusion of mental states and the consequent re-emergence of more primitive mental states is the core psychological deficit of patients with BPD which may have a profoundly damaging effect on helping to create, maintain and develop healthy interpersonal and in particular, close relationships (Gunderson 2007).

Mother-infant interaction for mother's diagnosed with BPD

It comes as no surprise, therefore, that parents with BPD can struggle to relate to their infants and present with mother-infant relationship difficulties. Mothers with BPD have been reported to be significantly less “satisfying/engaged,” or more “difficult” or “dysfunctional” mother–child interactions according to observation (Crandell et al., 2003; Newman et al., 2007) and maternal self-report (Elliot et al., 2014) in comparison to healthy controls. In addition, mothers with BPD have shown significantly less imitation, less smiling, touching, and playing with their infants than healthy controls (White, Flanagan, Martin et al., 2011). Hobson et al. (2009) further found that mothers with BPD displayed significantly greater “frightened/disoriented” (i.e., fearful, hesitant) interaction with their infants than mothers with depression or healthy controls.

Mothers with BPD have been shown to be less sensitive/have lower “non-intrusive sensitivity” with their infants compared to healthy control mothers (Crandell et al., 2003; Newman, Stevenson, Bergman, et al., 2007) with a significantly higher “intrusive in-sensitivity” towards their infants (Hobson, Patrick, Crandell, et al., 2005). In fact, Hobson et al. (2009) found that mothers with BPD symptoms were significantly more “insensitive” with their infants when infant distress persisted for longer durations. Furthermore, Mothers with BPD were significantly poorer than healthy controls at “infant emotion recognition.” (Elliot et al., 2014) are negatively correlated with “acceptance of individuation.” (Zalewski et al. 2014).

In terms of hostile behaviour towards their infants, Elliot et al. (2014) found that BPD symptom severity was significantly positively correlated with raised levels of maternal hostile/reactive behaviours and furthermore, mothers with BPD scored significantly higher than healthy controls on the “hostility” of a general psychopathology measure (Newman et al 2007).

Parents diagnosed with BPD have shown to express elevated worry, guilt, and uncertainty around the parenting role (Zalewski, et al., 2015). They have further shown to have unique parenting behaviours such as oscillations between hostile control (Barnow et al. 2006) and withdrawn behaviours (Zalewski et al. 2014; Harvey et al. 2011), as well as oscillating between intrusiveness/overprotection (Reinelt et al. 2014) and hostility (Herr et al., 2008; Frankel-Waldheter et al., 2015).

Attachment and transmission of vulnerability

Whilst unresolved/disorganized attachment style is strongly associated with BPD (Bakermans-Kranenburg and van IJzendoorn, 2009), attachment anxiety and BPD have also been linked (Levy, 2005).

Indeed, a cycle of vulnerability has been detected where a transmission of a range of difficulties and vulnerabilities from a parent diagnosed with BPD to their child can occur (Reinelt et al., 2014; George et al., 1984; Macfie et al., 2014; Gratz et al., 2014). This can include the intergeneration transmission of the traits associated with a disorganised attachment pattern (Fonagy et al., 2002; White et al., 2011).

Method

This is a sub-study of a wider Randomized Control Trial (RCT) which investigated the outcomes of psychoanalytic parent-infant psychotherapy (PIP) for parents with mental health problems and their young infants (Fonagy, Slead & Baradon, 2016). The primary outcome for the RCT was infant development and secondary outcomes included parent-infant interaction, maternal psychopathology, maternal representations, maternal reflective function and infant attachment. This study provided an additional qualitative perspective to get closer to the actual experience of how mothers, and in particular mothers with BPD traits, experienced changes in their relationship with their infants after they engaged in the PIP.

Recruitment

The RCT took place at four demographically diverse sites in England with socioeconomic deprivation. Referrals were made by health and social care professionals. The inclusion criteria for the RCT were;

- the parent had been independently identified by a professional as requiring additional mental health services,
- the child was less than 12 months old
- mothers met probably psychiatric case criteria based on the General Health Questionnaire (Goldberg & Williams, 1988) and
- mothers met at least one of the following indicators of social exclusion:
 - low-income household (eligibility for income support)
 - long-term unemployment (more than 2 years)
 - overcrowded or temporary accommodation (more than 2 persons per room)
 - unmarried and unpartnered
 - presence of chronic physical illness or disability
 - early childhood history of foster or institutional care
 - social isolation associated with recent relocation
 - less than 20 years old
 - previous diagnosis of nonpsychotic psychiatric illness.

Exclusion criteria for the RCT were:

- non-English speaking families
- current maternal psychosis
- chronic drug dependence/substance-abuse disorders
- maternal IQ of above 70
- infant with sensory or motor disability that may prevent participating in a standard developmental assessment.

In addition to the RCT inclusion and exclusion criteria, in order to include only mothers who had the PIP treatment and presented with BPD traits, the inclusion criteria for the participants in this IPA study were;

- participants randomly allocated to the PIP treatment group
- participants who participated in the follow-up interview at 6 months
- participants with a cut-20 score ≥ 10 in The Borderline Personality Inventory (BPI) (Leichsenring, 1999), a 53-item true/false self-report questionnaire which can be used as a screening instrument for BPD and also for dimensional research of borderline features. The measure yields four subscales which relate to Kernberg's description of borderline personality organization: identity diffusion, fear of fusion, impaired reality testing and primitive defenses (Kernberg, 1967). The 20 most discriminatory items are used to form a cut-off score (cut-20), which is likely to suggest a diagnosis of BPD according to the DSM-III-R (Leichsenring, 1999)

Participants

There were 3 cases that met the specific criteria for the current study based on the criteria above and all of these cases were included in this study. All of the mothers' infants were 9 or 10 months old when the semi-structured interview took place. Information about the participants' early life had been sourced from the Family Background Interview.

Carla, 21, was the youngest participant and her female infant in the study was her second child. She does not speak English as a first language and is not originally from the UK. She was isolated throughout the treatment, single and unemployed. Carla's baby was conceived by rape and she did not want to keep baby. She was suicidal after the birth of her infant, has been diagnosed with depression and takes antidepressants. Carla's mother died of medical causes in her childhood and when her father also died, she came to live in the UK.

Sian, 37, was the oldest participant in the study. Her male infant was her first child and she was British and lived with her partner, the father of her child. She was unemployed and the only participant who ended the treatment before the time of the interview as well as being the only participant who attended a mother and baby psychiatric unit.

Sian had a history of depression and drug addiction (heroin, crack cocaine, alcohol and benzodiazepines), and problems in relation to her partner who she felt suspicious of. She was isolated from own family and diagnosed with Post Natal Depression (PND) with paranoid episodes and she was medicated accordingly. Sian shared that she took overdoses as a teenager and suffered from panic attacks and depression. She described how her parents stopped her being treated for her mental health as an adolescent.

Mariana, 26, described herself as single and was the only participant who was employed and on maternity leave. She is not originally from UK and her female infant in the study was her first child. Carla was isolated, had problems with her partner but no diagnosis or addictions although she suffered from very poor mental health. There are no details of earlier history in the Family Background interview.

Procedure

The interview schedule was based on 'The Therapy Experience Interview' (see appendix 1), a semi-structured interview which focussed on the experiences that the mothers had of the PIP treatment and how they experienced changes in their relationships with the baby after engaging in the PIP treatment. It took place at 6 months after the PIP treatment began. The interviewers varied with each participant and the interviews proceeded with the minimum constraint by the investigator (Smith 1995). The questions were used flexibly and were open-ended to encourage participants to recount their experiences in their own words. The way that questions were phrased and how explicit they were varied depending on the responses of the participant. All interviews were audio-recorded with permission of participants and transcribed verbatim by various research assistants.

Analysis

The transcripts were subjected to Interpretative Phenomenological Analysis (IPA, Smith 1995, 1996). This method of analysis was used in order to capture the three participants' real experiences of the changes in their relationships with their infants' in detail.

Each transcript was initially thought about separately. The first transcript was closely read a number of times and the right hand margin was used to annotate interesting, significant insights about the participant's responses. Some of the comments were attempts to summarise the text, comment on the use of language, find similarities differences and contradictions, and make associations, connections and interpretations about the participant's answers and how they expressed their experiences. The entire transcript was treated as data (Smith et al., 1999).

Emerging themes to a higher level of abstraction were then documented below the text and colour highlighted accordingly. The emergent themes were listed and connections found between them. Some themes were clustered together whilst others stood as subordinate concepts. A table of the themes then clustered subthemes themes under each superordinate theme and directories of the participant's phrases in support of these were made.

The table of themes from the first participant was put aside. Following this, the second and then the third transcripts were worked on separately and each transcript was analysed first in its own terms. A table of themes from each participant emerged. This ensured an idiographic approach to analysis was followed where each participant was considered separately with a slow working of more general categorization or claims (Smith et al., 1995).

Once emerging themes to a higher level of abstraction were documented from the three transcripts, a cross-case analysis then explored convergences and divergences between participants' accounts. A master table of themes for the group was made which consisted of a list of superordinate themes and subthemes.

The analysis continued and was expanded on during writing up where the themes were translated into a narrative account, explained, illustrated and nuances found

and elaborated on. The meanings inherent in the participants' experiences were outlined and care was taken to distinguish between what the participants said and the interpretation of the response in writing up. The researcher's interpretative engagement with the text was necessary to make sense of the verbal accounts being analysed. This therefore included a co-constructive approach adopted, with participant and researcher both involved in the sense-making process (Smith 1996; Smith et al 1999).

Ethical considerations

The study had received NHS research ethics committee approval. Names of any participants and any exposing information such details of where the participants live were anonymised and the researcher only received deidentified data for analysis. Transcripts and audio tapes were stored in a safe place to ensure of confidentiality data for analysis. Furthermore, all participants were informed of the different aspects of the research to ensure of informed consent.

Results

The analysis of the complete data set identified two master themes capturing the mothers' experiences of the change in the relationship with their infants. These were 'improvements in the parent-child relationship' and 'continued difficulties in the parent-child relationship'. Whilst the mothers' experiences varied significantly, it was possible to find shared patterns of meaning illustrated within subthemes as well as point to differences between the participants' experiences.

Fig. 1

Improvements in the parent-child relationship	Continued difficulties in the parent-child relationship
It becomes easier with time	Helplessness
Comforting and closeness	Struggle making sense of emotions
PIP therapist support	Interpersonal relationship difficulties
	Continued mental health difficulties

To achieve this, as shown in fig. 1, three inter-related subthemes are reported within the first master theme; 'it becomes easier with time', 'comforting and closeness' and 'PIP therapist support'. Whilst all participants found that there were some improvements in the parent-child relationship with time and it became easier, the reasons for this and the depth of real and meaningful change varied according to each participant.

The four subthemes of; 'helplessness', 'struggle making sense of emotions', 'interpersonal relationship difficulties' and 'continued mental health difficulties' together illustrated 'the continued difficulties in the parent-child relationship which stands as the second master theme. Although all participants suffered from continued mental health difficulties, there were differences reported within the participants' experiences. What became most evident was the continued struggle of some participants to make sense of their own, others and their infants' emotions. This had the effect of maintaining difficulties with interpersonal relationships, feeling isolated, helpless and unsupported, which stood as an obstacle to being able to make real and meaningful changes within the parent-infant relationship.

Improvements in the parent-infant relationship

It becomes easier with time

In all cases, the participants noticed changes in their relationship with their baby over time. With confidence, Sian stated these changes were positive and describes how, as her baby gets older, her enjoyment that she had with her baby increased over time. Both Carla and Mariana were more tentative in how they described the changes in themselves and their babies over time. Mariana was aware that she felt less distressed as her baby got older and she linked this to being able to have more understanding for her baby as her own distress has reduced with time:

M: Well, past the six months you know I become you know a little bit more understanding for the baby like before I was so much distressed about everything...

Carla noticeably found it difficult to see changes in her relationship with her baby over time and described any changes with caution. It should be noted that Sian and Mariana are able to mention how and why they thought there had been changes in themselves, their baby and their relationship with their baby over time. However, Carla was unable to do this and it seemed to confuse her when she was asked how and why changes in the relationship with her baby had occurred.

I: And how do you think she feels about the relationship? How do you think it has changed for her?

C: I'm not sure. I don't know.

I: Ok. What is the reason for, for you feeling closer to her? What do you think?

C: Phew... I don't know...

Carla's use of the word "phew" in the text extract above suggested that being asked questions about how she felt about her baby was experienced as quite overwhelming for her, as if she was unable or unwilling to think about it.

Comforting and closeness

Sian eloquently described her relationship with her baby and on several occasions, she referred to how close she felt to her child:

I: And what about your relationship between you and your (baby). Has that changed over the past 6 months?

S: I think yeah definitely. It has definitely got stronger erm I think we are really close I think. Erm yeah we are really close.

She put this down to a number of factors such as feeling more relaxed within herself, being more able to calm her baby and having more enjoyment in her baby. Mariana also stated that she felt closer to her baby like Sian does and similar to Sian, she described an increase in confidence with her ability calm her baby down. Mariana described an improved ability in helping to regulate her infant's emotions. She located this source of change in her infant with transformations within herself first:

M: Um let me think now, how it was before, maybe now I feel maybe it because to do with me because now I feel more confident with her and now it's just easier for me to pick her up and she gonna stay well and comparing to before I think it was harder.

Again, similar to Sian, Mariana highlighted the enjoyment that she now got from her child which may have enabled them to have a closer connection. On a number of occasions, Sian linked her own pleasure in experiencing her baby's increased independence and his ability to have related well to others outside of their relationship. Mariana also described her satisfaction in watching her infant relate to others outside of their relationship. This could highlight some relief the participants gain as their infants took steps towards independence and were able to relate to people other than themselves. Furthermore, Sian and Mariana may have gained a sense of relief with the reduced intensity of the dependency relationship as their infants began to relate to others.

Sian only briefly touched on how she experienced her baby in his earliest and most dependent stages and this was in a more negative light to how she experienced him later on in the study. She described him previously as, '*quite a whingy little so and so*'. Mariana, however, described the earliest and most dependent stages of her infant's development as very difficult with a real struggle to calm her baby and therefore feel close to her:

M: She's more calmer now, she's more calm before she was very anxious, very body tense, everything and now I think she, she control things more or she feels better now.

Both Sian and Mariana were able to think more about how and why they felt that their relationship had changed with their infants over time. Their reasoning do somewhat differ although there were some overlaps. Both participants pointed to an increased confidence in comforting and understanding their baby but Sian went further to describe her abilities as a mum in a self-assured manner:

S: I think I've become more confident and more confident in being a mum, but I do actually know what I'm doing. I know my baby and I know what he wants and when he wants it.

Sian was quite clear in her thinking about how and why she had become more confident in her abilities as a mum. She pointed to professionals being positive, encouraging and supportive which had the effect of making Sian feel more confident and aware of her own strengths. Sian was the only participant that attended an inpatient mother and baby unit and she was also the only participant who was not socially isolated. In fact, she voiced her enthusiasm to attend groups and built up a social network with other mums. This experience enabled Sian to have improved relationships, helped to have increased her confidence as a mother and strengthened the bond with her baby. Sian linked the improvements in her social isolation to her positive attitude and prior changes in her medication which enabled her to feel that she could manage to take her baby to groups without feeling overwhelmed:

S: I just think because I've had the medication it's made me feel that I'm more able to cope. Because I am able to cope and go out with (baby) so I start doing things that I find that I enjoy them so it's not a stress or a hassle and you can do them.

In fact, Sian's use of language in the above extract suggested real change from how she experienced her life and her infant before. She uses "you" which suggested that she is saw herself from the outside doing these things with her baby confidently. Furthermore, her use of; "I find" hints that she might not have expected to be able to go out with her baby in the past without finding it stressful and she repeated the word "cope" as if she might have found it hard to believe in the past that she would be able to cope going out with her baby.

It was quite evident that Sian stood out as the participant who has the greatest sense of enjoyment from her baby and felt the closest to her child. This sense of enjoyment, closeness and pride may have been accentuated by the positive feedback she gained from others around her which could have had a further accentuating effect. Furthermore, with the increased distance she gained whilst her child interacts with others, she may have had more space to reflect on his positive qualities. Indeed, Sian described her baby's unique characteristics at length appearing seemingly proud that he was a separate individual from herself with his own character traits:

S: He's obviously developing his own personality so that's why he can be a bit more stubborn.

Carla, on the other hand admitted to only feeling a bit closer to her baby over time and was unable to put how she felt about their relationship into words. She could not explain how or why she felt closer to her child and did not mention any unique characteristics about her infant. This may imply that she continued to feel so overwhelmed with the experience of mothering her baby that it may feel too arduous and painful to think about her infant and how she related to it let alone the impact that she might have had on her baby.

PIP Therapist Support

Throughout the study, Mariana and Carla remained more socially isolated than Sian. The reasons that Mariana gave for feeling closer to her baby therefore differed to Sian. Whilst Sian did not locate the source of change from the support of her PIP Therapist, Mariana and Carla vocalised benefits from the treatment and both participants continued to be in treatment at the time of the interview. Mariana pointed to the support that she had gained from her PIP therapist which helped her to understand her baby more and strengthened the relationship she had with her baby.

Furthermore, Mariana was also able to use the support of her therapist to think about how her partner may have affected her emotions and impact that this may have had on her baby. She shared that her psychotherapist pointed out that she was able to stay calmer when her partner was not present which had the effect of her baby remaining calmer too. Indeed, from attending 37 of the 40 sessions with her PIP Therapist, Mariana had the highest attendance rate out of the participants.

Although Carla was unable to complete sentences when she described her therapist or recount in any detail the help that she felt the therapist had provided, she described her therapist as “*very loving*” and the experience was “*very positive*” which may have indicated more subtle changes linked to her therapist’s support. At this point, it seems important to note that Carla was offered 84 PIP sessions, the most of all participants and whilst she attended 49, she failed to attend 35 sessions. This highlighted her ambivalence with the treatment and might point to her reluctance in having to think about her baby in the presence of another person. It is relevant to

note that Carla did not plan to have her baby and the baby was conceived through rape. It is therefore likely that she continued to suffer from unresolved pain, internal conflicts and trauma. With this in mind, Carla's ambivalence to the treatment may be further accentuated by a defensive pattern of projecting which she admitted to when she described her PIP therapist:

C: Sometimes I got a bit upset with her. But no... the negative are... is the truth, you know. It hurts.

Carla's potential use of projecting painful feelings towards others may have given her some short term relief. However, projecting as a mechanism to defend against painful feelings, not attending appointments and not being able to locate the source of change within herself may have also served as obstacles to experiencing real and long term positive changes in the way she related to her baby.

Continued difficulties with the parent-child relationship

The way that Carla experienced the support from her PIP therapist points to how complicated the process of accessing support and internalising positive changes in relationship to her baby was which further maintained the difficulties in the parent-child relationship. Indeed, all participants faced some continued difficulties in life as a whole but Carla and Mariana stood out as having continued severe difficulties in the parent-child relationship.

Helplessness

Both Carla and Mariana suffered from continued feelings of helplessness and a state of mind where life felt difficult and hard. Mariana portrayed a bleak picture of how she felt and experienced life:

M: Now I have less this black days when you know I don't want to go out of the home... Maybe less you know but it's still, still I have, how to say it? Bad days, bad emotions, bad everything still.

The repetition of the word “*bad*” in the extract above illustrated the extreme language used by Mariana to describe her emotions and how she experienced life. Alongside this, she also showed evidence of uncertainty but this may well be linked to feeling unsure about expressing herself in English for example when she says; “*how to say it?*” Alongside her uncertainty, however, there is an overriding sense of longsuffering helplessness. By using the term; “*bad everything still*”, she implied that her bad experiences had remained and had been long lasting.

Carla implied that she had experienced more recent positive changes in her emotional wellbeing by stating “*it has changed a bit*”. However, throughout her interview, when she described how she experienced life, she repeated the terms; “*it’s a bit hard*”, “*it’s very hard*”, “*it’s not easy*” and “*it’s a bit difficult*”.

Carla’s account is complex as it was difficult to ascertain quite how distressed and helpless she felt due to a number of factors. She gave very brief answers and whilst this could have been linked to an avoidance of thinking more deeply about potentially distressing thoughts, it could also have been linked to her own confusion about her own and other people’s emotions. On the other hand, her short answers could have been linked to her difficulty in being able to find the words to describe herself more fully in English as English was not her first language.

At any rate, Carla expressed uncertainty as to what kind of ongoing support may have been helpful which may have furthered her sense of feeling stuck and helpless. Similarly, Mariana expressed a state of helplessness in being able to make any changes to improve her life:

M: Every single day you’re still in your life and you, you just wish to change it to do something but you can’t.

Mariana’s repetition of the term “you” whilst she described her life implied that she was watching it from the outside at a distance rather than experiencing it herself. This could suggest that she felt dissociated from her own lived experience which may have felt too unbearable and painful to have experienced in a more real way.

The struggle to make sense of emotions

Understanding emotions was confusing for Carla and Mariana. Indeed, Carla expressed confusion around her own basic states of mind throughout her interview. In a similar vein, when asked to describe her emotions, Mariana replied; *'I'm not feeling how I'm supposed to feel because I know, I'm not feeling normal.* Carla and Mariana's confusion of their own emotions may well have hindered their ability to have made improvements in the parent-child relationship.

Furthermore, Carla and Mariana showed signs that their infants' emotions confuse them. Carla, as stated before, used few words to express her confusion of her infant's emotional states. Again, this may be due to English not being Carla's mother tongue. However, when asked by the interviewer about the relationship with her infant, she replied; "I don't know" or "I'm not sure".

With more confidence, but also in a curious manner, Mariana described her infant as if she was describing an older child or adult.

M: She wants to scare you...To me it looks like she wants to, to look like big, big person. Yes.

This extract highlighted Mariana's confusion of her infant's expressions, needs and desires. It is questionable why she perceived her baby in a manner where she felt that her baby was trying to scare her and look like a big person. This suggests that she may have felt that her baby was controlling, aggressive and wanted to assert authority over her. It may also suggest that she was frightened of her own baby.

It is interesting to note that when Mariana and Carla were asked about the reasons for change in their relationship with their child, both of their initial responses were linked to their infants growing older. Sian, on the other hand, was able to reflect in greater depth and considered emotional and psychological reasoning behind changes to her child and the parent-infant relationship.

With pride, Sian also revealed a solid understanding of the individual characteristics that her infant exhibited in different environments over time. However, this ability was not shared by Carla or Mariana. Carla did not openly give a description of her infant

throughout her interview. Mariana, on the other hand did describe her infant but in an inaccurate manner and further in a way that showed that she struggled to see her infant as a separate individual from herself with its own individual characteristics.

M: I can see the mirror of myself so it's more interesting for me now

This extract demonstrated that Mariana denied differences between herself and her infant as she saw them as mirror images. In a narcissistic manner, her infant became more interesting to her as she felt that she had become more similar to her. This would have the effect of denying her infant's own individual characteristics, expressions and emotions and stand as an obstacle for a healthy mother-infant relationship.

Furthermore, the results also pointed to Mariana's confusion in her ability to understand her infant's self-expressions.

M: But if I come, it looks like she wants to run from me. She's so scared you know it looks like I say 'chop, chop, take the bottle'...and if I watched her eyes, she gonna close her eyes so she's kind of, it's like a respect for me.

In the extract above, Mariana misunderstood why her infant may be closing her eyes in her presence. For whilst she linked her infant closing her eyes to the respect her infant had towards her, a more likely explanation may be one of fear. This not only evidenced how confusing her infant's emotions could be for Mariana but also showed her over-intrusive and hostile manner in how she related to her baby.

Interpersonal relationship difficulties

All three participants had some problems with interpersonal relationship difficulties. Carla was not with the father of her child, she mentioned some sort of conflict with her social worker and some difficulties with her PIP therapist and she did not have extended family in the country or mention any friends.

Sian and Mariana were still with the fathers of their babies but whilst Sian described her partner as unsupportive and partly blamed him for her difficulties, Mariana stated that she was confused about her relationship with her partner and she linked her confusion with this relationship to feeling very vulnerable.

M: Uh well um there is still much confusion in my relationship with (baby's) father so I still feel very vulnerable you know.

This implied that she felt confused about how she felt towards him and the uncertainty was unsettling. This could also have been representative of other relationships she had due to her struggle to make sense of her own and others' emotions. Mariana further described her partner as someone who can “*corrupt*” and “*destroy*” her “*normal life*” and she described both herself and her baby as calmer when he was not present. Mariana, therefore, did not perceive her partner as a helpful presence to support her with the difficulties she faced with the mother-child relationship.

Perhaps linked to their difficulties with interpersonal relationships, Carla and Mariana continued to feel isolated and alone with their infants and this may have been a perpetuating factor in sustaining their continued difficulties. Furthermore, both Carla and Mariana were not British and this may have been a further perpetuating factor in feeling isolated, alone and unsupported as it may have been harder for these participants to feel accepted and integrated by other mums in their community as well as potentially not being aware of the support that was available to them.

Despite having difficulties with her partner and feeling isolated in the past, Sian mentioned a social network that she had built up around her infant which had reduced her sense of feeling alone and isolated. As Sian is British, this may have aided her ability to have felt more at ease than the other non-British participants to integrate herself within a social network for mums as well as being aware of further support that was available in her local community.

Continued mental health difficulties

A further perpetuating factor sustaining difficulties in the parent-infant relationship for Carla and Mariana could be their continued struggles with their own mental health. Sian had a history of drug use and diagnosed with depression and postnatal depression openly described the positive affect she experienced from changes made in her medication, the support she gained from an inpatient mother and baby unit as

well as the unofficial support she gained from building a social network with other mums.

On the other hand, Carla continues to take antidepressants and she gave a bleak portrayal of her current situation with few signs of hope to change. It was difficult to ascertain her current emotional wellbeing in detail due to her short answers in the interview.

Although Mariana had no diagnoses and does not take medication, she openly described her plight in finding happiness and her helplessness in knowing how or what support might help her. Both Mariana and Carla's mental health difficulties were heavily linked to their struggle in understanding their own and others' emotions which is a precipitating factor in sustaining continued difficulties within their parent-child relationships.

Discussion

Findings illustrate that, with the improvements in the parent-child relationship, all three participants found that it got easier with time to relate to their babies. Two participants, Mariana and Sian described feeling closer to their infants, were more confident in comforting their infants, had more pleasure in interacting with their infants and had an improved ability to regulate their infant's emotions. In terms of the reasons for this, Sian, who voiced the most positive changes in the parent-infant relationship, gained valuable support from attending an inpatient unit, had changes in her medication to good affect and found value in building up a network with other mums. What Sian and Mariana had in common was that they both gained a sense of relief and happiness as their infant's took steps towards independence and furthermore, in varying degrees, they both were able to locate the source of change within themselves.

The participant, Carla, who was found to have the least positive changes in her relationship to her infant, did not show an ability to locate the source of change in herself. Her short sentences and avoidance of thinking hinted at how painful and arduous it was for her to think about her infant, how she relates to her and what impact she may have on her infant. This highlights the participant's failures in

mentalization which is the capacity to make sense of self and of others in terms of subjective states and mental processes (Fonagy & Bateman, 2007).

On the other hand, Clara has English as an additional language and without hearing the transcripts, it is difficult to unpick what extent Clara's short and confused answers were linked to language comprehension issues and limited English language or her failures in mentalization.

The results showed that Carla and Mariana did give some positive feedback about their parent-infant psychotherapists. Whilst Carla, in a more limited fashion, described the parent-infant psychotherapist as a positive presence for her without including how the parent-infant psychotherapist helped improve her parent-child relationship, Mariana did state that her parent-infant psychotherapist helped her understand her baby more and helped her understand the impact that she may have on her baby. However, with both participants, these seemed to be only subtle changes in the context of their chaotic and somewhat difficult life experiences.

Indeed whilst considering the continued difficulties with the parent-infant relationship, both Carla and Mariana stood out as the participants who voiced long standing suffering and struggles with the complexities of life. They both gave a sense that life is hard and they felt stuck with an uncertainty of what ongoing support may be helpful to them. Whilst not denying the difficulties these two participants may endure, low levels of distress tolerance are associated with BPD (Gratz et al., 2006). This may therefore have the impact of an affective state feeling even worse for these participants to a comparison parent who does not have BPD traits. Whilst this study is small scale and it is crucial not to make generalisations, it does fit with above findings. One could postulate that some people with BPD traits may not have developed coping strategies to manage their unease and distress. Indeed, whilst Sian shared quite clear coping strategies such as building up a support network with other mums, the other two participants who voiced the most difficulty and helplessness did not mention any coping strategies to manage their distress.

It is important to discuss that both Carla and Mariana were not originally from the UK and did not speak English as a first language. This could have exacerbated their sense of helplessness, isolation and stood as an obstacle to access support

services. Despite this, many studies have documented the centrality of negative affect to BPD (Bradley et al., 2005; Skodol et al., 2002; Trull et al., 2003; Westen et al., 1992; Zanarini et al., 1998; Zittel Conklin & Westen, 2005). Negative affect refers to a tendency to experience anxious and dysphoric affective states (Watson & Clark, 1992) rather than positive mental states. Carla, in particular stood out as a participant where negative affect is prominent in her thinking.

As a means of coping with conflicting, confusing and overwhelming emotions, the results showed that Carla has appeared to use denial of thinking particularly in relation to her infant and her relationship to her infant. Mariana, on the other hand, at points may have used dissociation as a means of keeping overwhelming feelings at bay.

What needs to be considered here is parents diagnosed with BPD have significant challenges when they attempt to establish a relationship with their infant. A background of unresolved attachment related trauma is common which brings risk of traumatic and dysfunctional dynamics. Whilst this was certainly true in the case of Carla who related her depression to the death of her mother and who also endured the trauma of the manner in which her infant was conceived. Sian also described a history of depression since her adolescence and was drug addicted for over 10 years. Mariana's history, is somewhat less clear and she did not share her earlier experiences with her interviewer. Furthermore, a core finding in the results was that Carla and Mariana had failures in making sense of their own emotional states. Individuals with BPD are found to be less aware of their own emotions (Leible & Snell, 2004) and are less able to distinguish between emotional states, a term called emotional granularity (Barrett, 2004). In addition, these two participants struggled to make sense of their infants' emotions, expressions and desires, i.e. their mentalization skills were poor. In fact, recent evidence suggests that individuals with BPD show a tendency toward hypermentalization, that is, the over interpretation or over attribution of overly complex intentions or mental states, leading to inaccuracies and confusion between the mental states of self and others (Sharp et al., 2011, 2013). The results showed that Mariana in particular hypermentalized when she interpreted her infant as wanting to control, "look like the big person" and "scare" her which is neither age appropriate nor an accurate interpretation.

To help explain this mismatch in parent-infant communication, it has been found that parents with BPD were significantly poorer than healthy controls at “infant emotion recognition” (Elliot et al., 2014). Furthermore, mothers with BPD may have heightened sensitivity to infant anger (Downey et al., 2004) and this could help to explain why Mariana deemed her infant as perhaps more aggressive and controlling than an infant may be experienced to a mother who does not have BPD traits.

The results showed that Sian was the only participant who was able to describe, respect and promote the individual psychological, cognitive, social needs and desires of her infant. Whilst Carla was only able to think about the physical changes in her infant over time, Mariana, at points denied any separateness between her infant and herself at all and describes her baby as the “mirror” image of herself.

Of relevance here is that borderline personality presentation is negatively correlated with “acceptance of individuation” (Zalewski et al. 2014). This could have the impact of maternal over-intrusiveness as the infant’s own individual personality traits, needs and desires are not encouraged to flourish. Rather, as with Mariana, the dominating maternal figure may be deemed as over-intrusive, over-involved and hostile.

Maternal BPD symptoms have been significantly associated with offspring-perceived “maternal hostility” (Herr et al., 2008), and researcher-observed (Frankel-Waldheter et al., 2015) “maternal hostility”. Furthermore, mothers with BPD have been shown to be less sensitive and have lower “non-intrusive sensitivity” with their infants compared to healthy control mothers (Crandell et al., 2003; Newman, et al., 2007) with a significantly higher “intrusive in-sensitivity” towards their infants (Hobson et al., 2005) Indeed, Mariana showed signs of “intrusive in-sensitivity” and frightening maternal behaviour when she described her infant “closing her eyes” in “respect” of her. This pattern of dyadic relating with frightening maternal behaviour and avoidant eye contact in response is indicative of hostile-helpless states of mind (Lyons-Ruth et al., 2005) which is the manner in which a person mentally represents attachment figures in contradictory and malevolent ways.

Whilst the results showed that Mariana showed signs of maternal hostility and lower non-intrusive sensitivity, it could be speculated that Carla, with the absence of an ability to describe her child in a coherent manner was under-involved with her infant.

Indeed, a pattern of both laxness (Harvey et al., 2011) and under involvement (White et al., 2011) alongside intrusiveness (Hobson et al., 2005) and over-involvement (Reinelt et al. 2014; Barnow et al. 2006) can clearly be observed in parents with BPD.

This small study is not able to diagnose the attachment patterns of the parents and infants involved. However, a pattern of maternal under and/or over-involvement and hostility may severely undermine a healthy attachment relationship. Indeed the transmission of disorganised attachment behaviour is heavily associated with maternal BPD and disorganised attachment behaviour in offspring infancy (Gratz et al., 2014; Hobson et al., 2005).

Indeed, a core finding in this study was that all three participants had interpersonal problems, particularly with the fathers of their infants. Whilst this would no doubt put more pressure on the parent-infant relationships, it may indeed affect how they continue to relate to their infants. Carla's infant, for instance, was conceived through rape and this understandably had a negative effect on her relationship with her child.

Whilst one participant, Sian, found building up a social network with other mums helpful to improve her self-esteem and enjoyment from her baby, the two other participants did not mention such endeavours and described feeling alone and disconnected from others. It has been found that BPD is partly characterized by chronic instability in interpersonal relationships (American Psychiatric Association, 2013). Looking more closely at the reasons for social impairments, BPD patients have been described as highly vigilant to social stimuli. Social situations have been found to be potent triggers for emotional arousal and affective instability in BPD (Ebner-Priemer et al., 2007). In addition, a rejection-rage contingent has been found to be elevated with people diagnosed with BPD (Berenson et al., 2011). This provides some evidence that reactions to perceived rejection significantly explain the rage which is often seen in BPD and also may help to explain Carla and Mariana's lack of close relationships, avoidance of social situations and continued sense of aloneness. One can speculate that struggles with interpersonal relationships may also have a negative impact on how these two participants relate to their own infants.

Carla and Mariana describe continued difficulties with mental health problems which stand as a precipitating factor for maintaining difficulties in the parent-infant relationship. These two participants also had the most severe problems with mentalization and interpersonal relationship difficulties. Furthermore, whilst Sian managed to find appropriate support for her separate from the PIP treatment to help her bond, enjoy and interact with her infant, the evidence showed that Carla and Mariana continued to express a sense of helplessness after completing the PIP treatment.

Strengths and limitations

In terms of limitations of this piece of research, this three participant IPA study is small scale. Willig (2008) acknowledges that small qualitative studies are not able to make claims for generalisation. However, in elucidating experience of a given phenomenon we demonstrate that it is available within a society and patterns of experience can be found.

The semi-structured 'Therapy Experience Interview' used to obtain the results was not developed specifically to answering the current question this study and whilst some valuable results were gained, the questions could have been more specifically aimed towards the aims of this study to gain a fuller description of the participants' experiences.

In addition, as the researcher did not transcribe the original transcripts, some knowledge, depth and meaning could have been lost. Furthermore, the transcripts were short and in particular Carla's transcript. There was therefore a lack of nuance compared to an audio transcript. This creates a difficulty in extracting meaning and depth to the participants' experiences.

It is important to note that two of the three participants did not have English as their first language. This not only may have affected the participants understanding of the questions asked but also, could have affected the depth of their answers. Furthermore, this caused technical difficulty in unpicking the participants' difficulties in relation to language fluency and/or mentalization difficulties. Cultural differences of the two participants may have also played a significant factor in terms of responding to the interview and the intervention itself.

However, the results gained from the participants' experience derives from the bottom up, is rich in meaning because of this and the nature of IPA allows the researcher to gain an 'insider's perspective' (Conrad 1987) close to the participants' personal world.

Furthermore, whilst there is an abundance of quantitative studies have been undertaken in the subject of mothers with BPD and how they relate to their children, there are have been few qualitative studies looking into how mothers with BPD experience their relationship with their children. Similarly, there have been some quantitative studies undertaken which have gained insight into the types of treatment aimed towards improving the parent-child relationship for mothers with BPD. However, there have been no qualitative studies preceding this one which investigate how mothers with BPD or BPD traits experience changes in their relationship with their infants after engaging in an attachment based treatment. This study, therefore, stands alone in providing rich data measuring the real lived experiences of such mothers.

Clinical Implications

The complex nature of the BPD presentation severely impacted the effectiveness of the treatment and therefore improvements in parent-child relationships. For instance some participants' continued mentalization problems hindered their ability to accurately understand their own and their infants' emotions and the treatment did not appear to significantly improve two mothers' mentalization abilities. The clinical implications of this is that it highlights the complexity of assessing the mothers' experiences of their relationships with their infants because without an improvement in mentalization capabilities, the participants are likely to continue to struggle with understanding both their own and their infant's emotions. Therefore, they may also have a reduced capacity to sense any changes in their relationships with their infants which would be reflected in the results.

The continued chaotic lifestyles and feelings of helplessness in everyday life which would be addressed in psychoeducational treatment were not explicitly addressed in PIP. Some psychoeducational support aimed at supporting some participants to manage what might be described as chaotic lives may have been necessary prior to

taking part in an attachment based treatment. This may have the effect of reducing some participants' more overwhelming feelings so that they may be then able to more readily access an attachment based treatment.

Future research

To date, there are no evidenced-based psychoeducational and attachment treatments that have been specifically designed for mothers diagnosed with BPD. Such treatments ideally should have both a quantitative approach as well as qualitative exploration in order to measure the effectiveness of the treatment and the experiences of the participants who have taken part in the treatment. Further qualitative research would ideally involve larger studies with more than 3 participants to gain a fuller exploration of the participants lived experiences.

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Appendix 1.

The Therapy Experience Interview

The next few questions are about how things have changed for you and your baby since the last time we met.

1. To start with, we would like to hear about the changes you have noticed in yourself.

a) Could you tell me about any big changes you have noticed in yourself over the last six months, since we first met? (could you give me an example that might help me understand that/in what way?)

b) Now more specifically- Comparing how you were when we first met with how you are now, have you noticed any changes in terms of:

i) Your confidence in yourself as a parent? (If yes, could you give me an example that might help me understand that/in what way?)

ii) The enjoyment you get from being a parent to your baby? (If yes, could you give me an example that might help me understand that/in what way?)

iii) Your own mental health? (If yes, could you give me an example that might help me understand that/in what way?)

d) (If applicable) In thinking about the changes you have mentioned, what would you say the most important reasons might have been for the changes? (Prompt, anything happened in your family life, the child developing, other services that have been offered to you, the present service – ask participant to illustrate and explain)

2. We would also like to find out more about what changes you have noticed in your child.

a) Comparing what he/she was like before you started the therapy to how he/she is now, what were the major changes you noticed in your baby (If yes, could you give me an example that might help me understand that/in what way?)

b) Now thinking more specifically -- have you noticed any changes in your baby in terms of the following?

i) Feeding? (If yes, could you give me an example that might help me understand that/in what way?)

ii) Sleeping? (If yes, could you give me an example that might help me understand that/in what way?)

iii) Fussing or crying? (If yes, could you give me an example that might help me understand that/in what way?)

iv) How easy he/she is to comfort when upset? (If yes, could you give me an example that might help me understand that/in what way?)

c) (If applicable) In thinking about the changes you have mentioned, what would you say the most important reasons might have been for the changes in your baby? (Prompt, anything happened in your family life, just time passing, other services that have been offered to you, the present service – ask participant to illustrate and explain)

3a) And what changes have you noticed in the relationship between you and your baby over the last 6 months, since we first met? (could you give me an example that might help me understand that/in what way?)

b) (If talks about any changes) And what do you think the reasons for these changes might have been?

The next few questions are about how you found the support you received/are still receiving.

4a. Are you still seeing the therapist?

Yes ____ No ____

If no, how long did you see her for?

4b) On the whole, did you find the experience of the therapy to be positive or negative?

- Very Positive
- Positive
- Neither Positive nor Negative
- Negative
- Very Negative

c) What parts of the experience were most positive for you and your baby? (please as before it is very helpful if you can illustrate with examples)

d) What parts of the experience were most negative for you and your baby?

e) What changes do you think could be made to improve the treatment you received?

f) What was your experience of (name of site) where you were receiving the therapy?

Prompt – Were there things about the setting that you particularly liked/ disliked

Let me ask you some specific questions? Did you find it easy to get here/there?

Were you made to feel welcome when you arrived?
Did you feel safe in the setting?
Did you find the physical environment comfortable?
Did you feel your confidentiality was respected?
Would you recommend it to a friend to come to this setting?

Part 3: Reflective Commentary

JSNY5

Word Count: 4473

Introduction

This is a reflective commentary of my journey I have undertaken whilst undertaking research for the clinical doctorate in Child and Adolescent Psychoanalytic Psychotherapy. In order to provide a fuller picture, I have included my thoughts and reflections from the very beginning of my training.

I have shown how the process of learning about and undertaking research has informed my clinical work and visa versa. My empirical study was of central importance in discussing these processes. Furthermore, all research tasks that were completed have been included in the writing in order to help gain the sense of how much of a beginner to research I felt at the beginning of the training.

An informal tone using first-person personal pronouns has been adopted in order to get a more authentic sense of my own thoughts and feelings throughout the process. In addition, I have chosen to use weather metaphors as subheadings because the description of the weather felt like a helpful way to describe my feelings about being part of and attempting to complete the research element of the clinical doctorate.

Thick fog - the beginning

With no prior experience of conducting research, I very much had to start at the beginning. This was a part of the clinical training that I felt that I had to do and I dreaded the first year of research related lectures which consisted of a large group students from various courses. Every student, I imagined, had more experience than me and whilst we rapidly covered a range of research terminologies, I struggled to keep up. Additionally, I did not have a good grasp of what I needed to be familiar with, how familiar I should be with the material taught and how much time I should be giving this part of the training.

Early on in the term, my year group gathered and we were told the timescales of each deadline for the research part of the course over the four years. I took myself home after the seminar and fell asleep, it all felt too overwhelming. So, from that

point on, I thought about each assignment at a time working towards manageable chunks of the course to get by.

I somehow passed an exam at the end of the first year and the next formally assessed piece of work was an audit. I was initially unclear how to undertake an audit or even what an audit was. However, with time and much support from the teaching staff, I got a good grasp of what I needed to do. I decided to focus on what support families were given in my CAMHS clinic who had a child diagnosed with ADHD and medicated. I felt engaged in the task and interested in the topic.

After a couple of weeks of digging for figures in the CAMHS clinic about how much psychological support families were given, I began to see the reality of a very chaotic service with near to no psychological support for families. I was given the cold shoulder by a few colleagues from the ADHD team and decided as I was planning on staying in the clinic for at least the next three years, I would abort the topic and focus on a less heated and politically charged area. A learning curve so far, therefore, was balancing my desire to expose a poorly run service that did not meet the NICE guidelines with my own training needs to fit in with my colleagues at a service working with limited resources under extreme pressure.

To my surprise, I found myself enjoying putting the audit together despite its rather bland subject that I chose – to compare the types of referrals for tier two and tier three CAMHS. The data was relatively straight forward to gather and I revelled in producing a document where the data could be illustrated in clear and engaging ways for the reader.

On reflection, perhaps the somewhat hostile experience of gathering data for my initial audit was a reflection of the experiences that children diagnosed with ADHD and their families have to bear at the CAMHS clinic – that of being silenced and unsupported. It is interesting to note that all three of the young people diagnosed with ADHD that I saw clinically refused to take their medication prior to starting their individual psychotherapy. Their refusal may demonstrate a sense of control and ownership of their treatment for ADHD. But in addition, all three patients vocalised their frustrations in what they described in their own words to be an inappropriate

and unhelpful treatment – namely that prescribing medication with little other support.

This topic for my initial audit could have had much greater scope to inform my own and other practitioners' clinical practice in the CAMHS clinic and at the time, I had hoped that it may lead to my research study. In any case, from this experience, I am now more aware in my clinical work that these children, young people and their families may feel unheard, and perhaps silenced.

Such a rich topic initially was replaced by what felt like a blander audit which I do not feel informed my clinical work to such a great extent although I was surprised by the complexity of Tier Two patients' symptoms as well as the length of time that the symptoms had manifested. Both of these factors I was previously unaware of. This informed my practice as it highlighted just how long patients' had been living with their symptoms if they had been seen in both Tier two and Tier three.

Although the results gained were used by Tier two and Tier three Managers, the topic did not act as a means for further thought and reflection within the team. This in itself is interesting as my own experience of this specific CAMHS team is that thinking and reflection were often shut down.

What next? My next task was to work in a group and think about producing a research project together. Again, with no prior experience of this, I felt quite infantilised and desperately wanted to be handheld by our seminar leader every step of the way. The weekly research related readings that I read and the group discussions in journal club helped me understand the format of research papers and what makes for more credible research. I felt a skill was being developed, a cog in my brain was beginning to turn but it did not come naturally and I still very much felt that the research part of my course was something that I needed to do to complete my training – a box that needed to be ticked.

Mist - the research cog starts turning

But perhaps this was not really the case? I found myself being able to engage in conversations in my CAMHS multidisciplinary team meetings that I otherwise would not have been able. For example, I questioned whether an art therapist should be

present in evaluating his own therapy group using semi structured interviews after the group took place. Also, an outside speaker came to the clinic to describe a Randomised Control Trial (RCT) and I was not only very familiar with this type of research now but I felt that I had the confidence to contribute to the conversation. Perhaps I was actually beginning to reap the benefits of all this extra research work, this new language that I initially saw as such a burden.

When deciding on our research topics, I gave a preference for my study to be linked to the PIP study. I am really interested in how mothers interact with their infants and I wanted to have more in-depth knowledge in this subject area. I also wanted my empirical study to be a neat piece of work I hopefully would not get too bogged down by.

I was now encouraged by my research tutor to think of a subject title within the PIP study in which to focus my empirical study. Narrowing down the area came with ease as my interest in Borderline Personality Disorder (BPD) had grown since commencing the training. I had been struck by how many parents had presented with borderline traits in the clinic and I was keen to know more about the disorder, its effects on their offspring and how best to support parents. Some of the looked after children that I had seen for psychotherapy described their parents' who sounded like they may have BPD and the impact of their condition had grave effects on both themselves and their relationships with their children. I was keen to know more to help explain these behaviours and the motivations behind them.

Meeting with other students in my year group for small group supervisions felt frustrating as we were at different points in thinking about our research proposals and my time felt too precious to be listening to other students ponder over their ideas. I wanted my supervisor's full attention for my proposal and then to cut and run. Meeting for seminars with our larger year group to discuss our research proposals felt equally frustrating. I was keen to get going with my own ideas, despite still finding the idea of undertaking my empirical study as an impossible task.

Sunny spells - the literature review

Midway through my maternity leave, I was eager to start my literature review and it was a welcome relief from talk of babies, nappies, feeding and weaning etc. I

regularly used my child's nap times to focus on the task ahead. I was struck by how engrossed I became in the process of finding all papers linked to the treatment outcomes for interventions that aim to improve parenting or parent-child relationships for parents diagnosed with BPD. In fact, I felt that I had enough time to even read other papers that were not specifically related to the literature review just out of sheer interest and curiosity.

The process of using a number of databases and Mendeley was all new to me but fairly straightforward and I found myself learning a great deal about BPD and parenting. The research showed not only a gap in evidence-based approaches specifically for parents with BPD and their children but also that there are no treatments that stand alone as interventions that have been specifically designed for mothers diagnosed with BPD to improve their parent-child relationships. I remember thinking that this finding felt very shocking to me at the time. For I was beginning to find that BPD severely affected parent-child relationships in a number of ways and a lack of support for parents diagnosed with BPD seemed somewhat limiting.

The literature review also highlighted the differences in approaches in parenting interventions which were primarily attachment-based approaches and/or psychoeducational approaches. Prior to beginning this literature review, I had mixed views about what might be the most successful approach in supporting parents with BPD. On the one hand, I had been involved in supporting young people who were taking part in the Systems Training for Emotional Predictability and Problem Solving (STEPPS) program in my CAMHS clinic. This followed a psychoeducational approach and I could see first-hand the benefits that this had on many young people struggling with emotional intensity disorders. However, I also held the previous belief that an attachment-based psychotherapy may help parents improve their mentalization capacities. Much of the research that I gathered for the literature review, despite the limited evidence base, showed that initial psychoeducational support is beneficial in order for attachment-based therapy to be accessible for parents diagnosed with BPD.

This finding therefore challenged my previous beliefs and assumptions about attachment-based approaches in supporting parents with BPD. For a purely

attachment-based approach in supporting these parents did not seem to be the recommended treatment. This all felt very new and interesting to me.

Light showers - the empirical study

With the literature review now completed in my third year and my maternity leave finished, I was back at the clinic and had the arduous task of the empirical study ahead. I was consciously aware that I wanted keep the study simple, for it to be achievable within the limitations of time which was bombarded by both clinical work and now a family life.

I was drawn to undertake a qualitative piece of work rather than quantitative for a number of reasons. Firstly, I felt completely inept at doing any sort of statistics and secondly, I am fascinated by gaining insight into the meaning behind human behaviour rather like a detective at work. Hermeneutics was a concept I got more familiar with. The idea of doing a qualitative study felt doable and potentially interesting.

However, my research question was very much limited to the data already obtained in the PIP study and therefore, although I had an area that I was more interested in, there were many restrictions. I created an empirical study where the question was revolved around the data already gained rather than vice versa. There were substantial limitations to this. For example, there were no mothers who had been formally diagnosed with BPD who had taken part in the study. Rather, participants with a cut-20 score ≥ 10 in The Borderline Personality Inventory (BPI), a questionnaire which can be used as a screening instrument for BPD and also for dimensional research of borderline features, was incorporated in my study. The PIP study had three participants with a cut-20 score ≥ 10 in The Borderline Personality Inventory (BPI) and this is how the number of participants for my empirical study was chosen.

I chose interpretative phenomenological analysis (IPA) as a method of analysis in order to attempt to gain an understanding of the real experiences of the three participants. I liked the way that the method was an in-depth account that privileges the individual as well as being a process that interprets how the participants make sense of their own experience over time. Furthermore, it felt exciting that there has

been no qualitative research undertaken to date taking into account the experiences of parents' with BPD in how their related to their infants after taking part in an attachment focussed intervention.

I had a lot of teething problems when I first started the process of undertaking IPA and found it difficult to get the level of analysis right. It took many weeks to get the level of interpretation right but I was eventually told eventually by my research tutor that I had managed this task.

The thoughtful process of getting the level of interpretation just right for IPA interestingly helped me reflect on my clinical practice of interpretation with my patients. For some of my patients, interpretations may feel unbearable and/or confusing and I therefore make a clinical judgement to keep them to a minimum if at all. For other patients, I can use interpretations in the room more frequently to good effect. However, similarly to IPA thinking about and reflecting on the key themes is at the heart of analysis whether or not an interpretation is actually made.

Furthermore, having been used to reflect on key themes in my clinical practice, the task in doing this in my IPA study did not feel alien or arduous. In fact, it felt very similar to a skill I was attempting to master in the therapy room within a different context and applied in a different way.

There were a few methodological choices that I made which looking back, I would manage differently. For example, there was a loss in that the transcripts were already transcribed. Despite this saving a huge amount of time for me, I think the nuances and much of the detail was lost from not having undertaken this task myself. This is particularly the case as two of the mothers did not speak English as a first language and parts of the written transcripts were difficult to understand. In addition, I used data from 'The Therapy Experience Interview', a semi-structured interview which focusses on the experiences that the mothers have of the PIP treatment and how they experience changes in their relationships with the baby after engaging in the PIP treatment. However, the questionnaire was not specifically designed for my empirical study and the questions could have been more specifically geared towards my study to gain a fuller understanding of the participants' experiences over time.

Furthermore, I chose to use just three participants for the reasons described above. However, I was unable to make any ethical generalisations from just three participants and this felt like a loss. Perhaps I had begun to get excited that my empirical study really did mean something and it had a useful and valuable place in how these participants experience changes in their relationship with their infants after engaging in an attachment-based PIP treatment. The fact that only three participants were included in the study somewhat disappointingly discredits this.

I also wonder what the impact of my research supervisor's profession could have been on my study for she is a Research Psychologist rather than a Psychotherapist. My phantasy is that she helped me to keep on task and produce the tidy and precise study. However, perhaps her training brought with it some losses in that interpretations from a psychoanalytic point of view was amiss in our discussions together during supervision and perhaps within the empirical study itself.

Sunshine - the delights of learning and links to clinical work

The great philosopher Aristotle (1967) stated:

'The greatest of all pleasures is the pleasure in learning.'

Indeed, the satisfaction that I have gained through undertaking the tasks related to the research element of the course have been immense largely because my knowledge base was so basic when I first started the training. It is as if I have walked uphill through fog, mist, cloud and approached sunny spells as well as light showers to get to the top of a mountain. In full sunshine, I am now able to enjoy the view. My empirical study is in no way a masterpiece but the processes of undertaking it has been challenging, enjoyable and satisfying.

I feel blessed to have been given the opportunity to learn about undertaking research and taught by inspiring and experienced researchers along the way. Being a Child Psychotherapist in the NHS is just not enough these days. Our profession must be informed by credible, evidence-based practice and I now not only have some skills to understand and unpick research studies but also undertake further research. I believe that going forward, Child Psychotherapists do need to be researchers as well as practitioners in order to be well recognised in the NHS.

The research element of my course has now informed my clinical practice in a wide range of ways. However, as my journey through the doctorate evolved, the two very different elements to the training, the clinical and the research, have felt mainly separated. This could be due to undertaking much of the research work at home, particularly during my maternity leave when I did not have the opportunity to apply the learning to my clinical work. Perhaps I also kept them separated in my mind in order to cope with and manage the requirements of the training. Now, that I have completed the empirical study, I am more able to reflect on the many outstanding ways that the learning from my research has informed my clinical practice and how I am now able to apply this.

For instance, the 'rejection-rage contingency' (Downey, Mougios, Ayduk et al., 2004) is a concept that became familiar to me from undertaking my literature review. It is related to the heightened sensitivity to negative emotions of others and the anger bias linked to rejection sensitivity which people diagnosed with BPD often have. In other words, it is the disposition to anxiously expect, readily perceive and intensely react to rejection.

Keeping this in mind during my clinical practice, with two mothers who have borderline traits with whom I have close communication, I have ensured to answer their telephone calls and concerns promptly and with a lot of care and precision in order to prevent them from feeling abandoned and potentially become angry. I believe this has held the therapeutic frame for their children in treatment with me which may otherwise have the potential to be 'trashed' by their parents' anger.

In fact, the learning from the literature review and the empirical study has improved my understanding of the difficulties and struggles that parents can face and consequently how I attempt to support and communicate with parents. I feel that my own sensitivity towards the difficulties involved in parenting and how I reflect on the family as a whole has changed. Prior to undertaking the parent related research, I was quicker to blame parents for the negative impact that they may have on their children. The 'transgenerational transmission of vulnerabilities' (Reinelt et al., 2014; Macfie et al., 2014; Gratz et al., 2014) has improved my understanding of the intergenerational complexities and difficulties that many people with BPD unfortunately have to cope with.

However, it is also important to take into account that since starting the research I have become a mother myself and this is also likely to have contributed towards my awareness of the difficulties and struggles that parents can face on a daily basis.

Two of the participants included in my empirical study showed evidence of 'hypermentalization' (Sharp et al., 2011, 2013). That is, the over interpretation or over attribution of overly complex intentions or mental states, leading to inaccuracies and confusion between the mental states of self and others. Awareness of this has affected my clinical practice in that I am more aware of keeping my language simple and to the point with certain patients and parents. I have learned that certain psychoanalytic interpretations, for instance, are not appropriate to use with some patients who may have borderline traits as they may find them more confusing than helpful.

One of the most important links that undertaking research had on my clinical work was questioning whether attachment-based approaches including individual psychotherapy are actually the right treatment for some patients who were referred to me at my clinic. For the literature review highlighted the benefits of psychoeducational approaches prior to attachment based approaches for parents diagnosed with BPD and this has made me question my own practice as a psychotherapist in training. I began to ask myself questions such as; should young people with BPD traits be offered practical and psychoeducational support prior to or alongside the psychotherapy? Should I adapt my practice to incorporate this? Is psychotherapy too overwhelming or confusing for some patients with BPD traits?

Furthermore, my empirical study raised the question whether other types of support for parents may actually be more effective than psychoeducational or attachment-based therapy. Indeed, the participant in my empirical study who was able to see the most amount of positive change in how she relates to her infant over time was the mother who had the least amount of PIP sessions. She was the same participant who was able to make connections with other mums in the community and got a lot of pleasure out of other people enjoying her baby and this seemed to be the main contributing factor which improved her relationship with her infant.

Applying this to my own work I questioned whether some children and adolescents who were referred to me for individual psychotherapy would be better supported by other means. For example, being provided with support to learn a new skill and helped to make connections with other children their age rather than be offered individual psychotherapy.

Apart from the reasons why I chose my research topic, I found it much harder to reflect on how my clinical practice informed my research. I suppose in my choice in research method, that of IPA, I swayed towards the familiar where I had learned to find emerging themes in my clinical practice and interpret communications. In this way, my clinical practice informed my research and the two worlds came together. However, there are tensions between the means of interpretation in that my clinical practice involves interpreting the unconscious whereas with my IPA study, meaning was given to the transcript and attempting to interpret the unconscious would be inappropriate and too subjective.

Furthermore, my clinical notes are written in a non-emotive way and are more similar to the writing style of my IPA study than the style that I have adopted to write my clinical papers. In this way, my clinical practice partly informed how I wrote the IPA study. Indeed, there are numerous ways that the academic writing style that I learned to use was different to the clinical papers that I wrote such as the ways of referencing and being objective and factual rather than adopting a more subjective and emotive tone used in clinical papers. Indeed, as I naturally enjoy writing in a more subjective and emotive way, I felt there was a loss in omitting my own feelings in my IPA study.

A further way that my clinical practice informed my research was the way that I chose the emerging themes for my IPA study, attributed meaning to the participants' communications and reflected on their relevance as well as finding possible links. These are all skills that I learned in my clinical practice which could be usefully applied whilst undertaking the IPA study.

Conclusion

I have shared my experience of my journey as a beginner to research, to completing a number of research related tasks towards finally completing an empirical study. I have described my struggles along the way as well as the unexpected satisfaction that I gained from undertaking and completing the research related tasks. I compared the experience to weather related metaphors with the final metaphor being sunshine on top of a mountain enjoying the view after climbing the mountain in various unpleasant weather conditions below.

I questioned the impact that my research supervisor may have had on my learning in that she was from a background of clinical psychology rather than psychotherapy.

I was fortunate enough for my literature review and empirical study to be both of interest to me and relevant to my clinical practice so I could apply learning gained. This included questioning own practice and the value of attachment-based psychotherapy. Ways that my clinical practice informed my research were also discussed, although this did not feel as prominent as the learning gained in my clinical practice through undertaking the research.

Finally, I may well always feel more drawn to being a practitioner rather than a researcher but my confidence as a researcher has grown throughout my clinical training. I now have awareness and determination to be part of evidence-based research in order to save, support and promote my profession as a Child and Adolescent Psychoanalytic Psychotherapist.

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