Mindful Parenting Group Intervention for Mothers with Borderline Personality Disorder Traits: Program Development and Evaluation

Natasha Catherine Rogers

School of Psychology, Faculty of Health, Arts and Design

Swinburne University of Technology

Submitted in partial fulfilment of the Doctor of Psychology (Clinical Psychology)

December, 2016

Abstract

The Australian clinical practice guidelines for the management of BPD recommend that "people with BPD who have infants or young children should be provided with interventions designed to support parenting skills and attachment relationships" (National Health and Medical Research Council, 2013, p. 120). However, a review of the literature reveals surprisingly few interventions that specifically target parenting for mothers with BPD (Stepp, Whalen, Pilkonis, Hipwell, & Levine, 2012), with interventions for BPD and for parenting being typically distinct and unintegrated.

This thesis aimed to address this gap in the treatment and research of parenting interventions for mothers with Borderline Personality Disorder (BPD) by developing and evaluating a group intervention that incorporates aspects of parenting interventions, and three major BPD treatment approaches (dialectical behaviour therapy, mentalization-based treatment, and acceptance and commitment therapy) that are of particular importance for promoting positive changes in parenting for BPD mothers. This study argues that an intervention program that integrates these treatment components can successfully address BPD-specific parenting issues experienced by mothers and facilitate positive changes in parenting and in the mother-child relationship.

A 12-session program, the 'Mindfulness-Based Parenting Group Intervention for Mothers with Borderline Personality Disorder Traits' (MPG-BPD) was piloted twice in Melbourne, Australia, with seven mothers (M_{age} = 41.14, SD = 6.96) whose symptoms met *DSM-IV-TR* criteria for BPD (American Psychiatric Association, 2000) or reached subthreshold levels of BPD. Questionnaire and interview data was collected at pre-program, post-program, and six-month follow-up. A mixed-method approach to data

analysis was implemented in order to provide a comprehensive evaluation of the MPG-BPD program. Quantitative and qualitative analyses were performed for the group data, and then case analyses were conducted to triangulate the quantitative and qualitative results. Following participation in the program, there were a range of positive outcomes found for participants in parenting, in the experience of being a mother, and for the mother-child relationship. Additional program outcomes included improvements in emotion regulation, mindfulness, reflective functioning, BPD symptom severity, depression, stress, self-concept, and self-care.

Quantitative and qualitative participant feedback was analysed to evaluate the program outcomes and processes. The program evaluation results differentiated the MPG-BPD program from other parenting interventions, with program processes playing a major role in a positive program experience for the participants as individuals and as mothers. The program processes implicated in this included the focus on individual difficulties with parenting, and more generally, a non-judgemental compassionate stance modelled by the facilitators, the experience of sharing in a supportive and accepting group environment, therapeutic disclosure, and program flexibility. Participants found the program content to be highly relevant and/or useful, and identified mechanisms of change that included attachment theory, reflection on family of origin, the 'good enough mother' concept, mindfulness, and self-compassion.

Overall, the findings of the present study support the thesis that the MPG-BPD program is an effective intervention for addressing BPD-specific parenting difficulties experienced by mothers with BPD and BPD traits, and results in positive changes to parenting, the mother-child relationship, and general psychological functioning.

Acknowledgements

First and foremost, I would like to acknowledge and thank the women who took part in the pilot program and research evaluation of the 'Mindful Parenting Group Intervention for Mothers with Borderline Personality Disorder Traits' (MPG-BPD). They were courageous in their openness and honesty about their parenting experiences and personal challenges, which were at times distressing and difficult. Their contribution to this research is greatly appreciated and will be of benefit for the future development of interventions for mothers with Borderline Personality Disorder.

I would like to especially thank and express my gratitude to my primary supervisor, Dr Roslyn Galligan, for her guidance and support throughout the last five years. Thank you for your encouragement and for believing in me from the first time I proposed the idea of developing this intervention program. Your enthusiasm and belief in the value of this research has been inspiring. Thank you for your assistance with the program design, the facilitation of the pilot groups, and for providing such helpful advice and comprehensive feedback. Thank you for helping to make my dream of developing a valuable intervention program for women with BPD a reality!

I would like to acknowledge and express my thanks to Dr Katie Wyman from Spectrum for her guidance and support with the development of the MPG-BPD program. Thank you for your great advice, for being so generous with your time and effort, and for sharing your wealth of knowledge about BPD treatment and facilitating group programs for BPD.

I would also like to express my appreciation and gratitude to Dr Sunil Bhar for taking the time to read this thesis. Your guidance and feedback was invaluable as it helped me to stand back and see the wood for the trees!

I would like to acknowledge the student co-facilitators of the MPG-BPD program for their effort and dedication in conducting interviews, facilitating the program, and peer supervision. Jennifer Nicholls and Katerina Volny, thank you both for all of your contributions, experience and support throughout the program implementation.

I would also like to thank Banyule Community Health for referring clients to the MPG-BPD program and for allowing it to be piloted at your service.

I would like to express my deepest appreciation and thanks to my husband Jason for his unwavering support over the past five years. It has been a long journey for both of us and I am incredibly grateful for your strength, encouragement, love, understanding and patience. Thank you for the emotional, practical and financial support that enabled me to complete this thesis.

I would like to express my gratitude to my parents Judy and Kent for the time and effort they put into proofreading this thesis. Thank you for your love and encouragement over the years. I wouldn't be the person I am today without your unwavering support. Thank you for always believing in me.

I would also like to thank my friends for being so supportive and understanding over the years, particularly Sarah, Imogen, Faye and Tam - thank you for the peer-supervision and advice, for the coffee breaks, dinners and drinks, and especially for keeping me sane through the thesis writing process!

Declaration

I declare that this thesis contains no material which has been accepted for the award of any others degree or diploma. To the best of my knowledge, this thesis contains no material previously published or written by another person except where due reference is made in the text of the thesis.

I warrant that I have obtained, where necessary, permission from the copyright owners to use any third party copyright material reproduced in this thesis, or to use any of my own published work in which the copyright is held by another party.

Natasha Catherine Rogers

Table of Contents

List of Tables

List of Figures

List of Appendices

Chapter 1: Introduction and Rationale for Developing a Mindfulness-Based Parenting Group Intervention for Mothers with Borderline Personality Disorder Traits

1.1 Introduction

There are a number of environmental factors that contribute to the development of Borderline Personality Disorder (BPD), including the experience of trauma and attachment dysfunction (Battle et al., 2004; Bradley, Jenei, & Westen, 2005; Herman, Perry, & van der Kolk, 1989; Soloff & Millward, 1983; Weaver & Clum, 1993; Zanarini et al., 1997; Zanarini et al., 2002). The symptomatology of BPD together with a traumatic attachment history can result in individuals with BPD being particularly vulnerable to encountering numerous difficulties with parenting and the mother-child relationship (Bland, Williams, Scharer, & Manning, 2004; Hobson, Patrick, Crandell, Garcia-Perez, & Lee, 2005; Lamont, 2006; Newman & Stevenson, 2005). These difficulties impact on their children and can result in a range of developmental issues and problematic psychological and behavioural outcomes. Children of mothers with BPD have been found to have a high risk of experiencing emotional, social and behavioural problems, suicidal ideation, and for developing psychological issues and psychiatric disorders (Barnow et al., 2013; Barnow, Spitzer, Grabe, Kessler, & Freyberger, 2006; Macfie & Swan, 2009; Reinelt et al., 2013; Weiss et al., 1996).

The Australian clinical practice guidelines for the management of BPD make a recommendation that "people with BPD who have infants or young children should be provided with interventions designed to support parenting skills and attachment relationships" (National Health and Medical Research Council, 2013, p. 120). Stepp, Whalen, Pilkonis, Hipwell, and Levine (2012) reviewed recommended interventions for

mothers with BPD, and the authors reported that "interventions designed specifically for mothers with BPD and their children do not exist" (Stepp, et al., 2012, p. 82). The clinical practice guidelines acknowledge that the evidence base about BPD is limited in both scope and scale, and identified that further research is required in a range of areas that include "interventions targeted at mothers with BPD to improve parent-child relationships and improve psychological, social and developmental outcomes for children" (National Health and Medical Research Council, 2013, p. 133).

There are surprisingly few interventions that specifically target parenting for BPD mothers; rather interventions for BPD and for parenting are typically distinct and unintegrated. This treatment gap is problematic as the existing parenting interventions may not be sufficient to address the particular difficulties experienced by mothers with BPD, and BPD treatments usually do not specifically address parenting issues. This necessitates the development and research of parenting interventions that are designed specifically for mothers with BPD.

1.2 Aims and Methodology

The overarching proposition of this thesis is to address this gap in treatment and research by developing and evaluating a parenting intervention for mothers with BPD. The first aim was to develop a group intervention that incorporates aspects of attachment-based parenting interventions and three major BPD treatment approaches (dialectical behaviour therapy, mentalization-based treatment, and acceptance and commitment therapy) that are of particular importance for promoting positive changes in parenting for BPD mothers.

The second aim was to pilot and evaluate this parenting intervention with mothers diagnosed with BPD. Due to difficulties in the recruitment of participants from

this population, the inclusion criterion was expanded to include mothers with subthreshold BPD symptoms (i.e., met diagnostic criteria for three or four symptoms). Therefore, the program was piloted and evaluated with mothers who had BPD traits or a diagnosis of BPD.

The program aimed to facilitate positive changes in parenting and in the mother-child relationship. To accomplish this objective, the program targeted the development of skills in mindfulness, reflective functioning, and emotion regulation. Additionally, there was a focus on increasing the mothers' awareness of attachment patterns by making non-judgmental connections between their childhood parenting experiences and the current approach to parenting. A secondary program goal was to facilitate improvements in participants' general psychological functioning.

Quantitative and qualitative measures were utilized to evaluate program processes and outcomes. On account of the small sample size of seven participants, non-parametric tests were used for quantitative data analysis. Interpretative Phenomenological Analysis was chosen as the qualitative analytic method for revealing themes and patterns in semi-structured interviews. Qualitative analysis was conducted to elaborate, enhance, clarify and expand upon the quantitative results. Finally, the results of non-parametric analyses of individual participant quantitative data were triangulated with the participant's qualitative interview themes in order to assess individual participant changes across three time-points (i.e., pre-program, post-program, and six-month follow-up). Case analysis was conducted for all seven participants due to the small sample size and in order to converge and validate the quantitative and qualitative results.

1.3 Thesis Overview

Chapter 1 provides a general overview of the thesis. Chapter 2 reviews the historical background of the borderline concept, clinical features of BPD, diagnostic comorbidity, prevalence, prognosis and the aetiology of BPD. Chapter 3 provides a comprehensive overview of attachment organization and the impact that attachment dysfunction has on the development of BPD symptomatology. Evidence supporting the established association between insecure attachment patterns and BPD traits are discussed as a conceptual foundation for psychotherapeutic approaches used for BPD treatment and to provide support for incorporating attachment-based approaches in a parenting intervention for BPD mothers.

Chapter 4 reviews the conceptual foundations and effectiveness of three BPD treatment interventions (dialectical behaviour therapy, mentalization-based treatment, and acceptance and commitment therapy). A case is made that mindfulness is the shared fundamental component of these approaches and that the development of mindfulness for those with BPD can result in improvements in BPD features, self-regulation, and parenting. The efficacy of mindfulness-based interventions is reviewed, with a focus on attachment and emotion regulation to support the argument that a mindfulness-based treatment approach may be particularly beneficial for BPD.

Chapter 5 provides an overview of the literature about children of mothers with BPD and parenting difficulties experienced by mothers with BPD, with a focus on maternal sensitivity, emotion regulation, parental reflective functioning and self-perception. It is proposed that these difficulties are related to the mothers' early attachment experiences which affect their own parenting behaviours as these are modelled on their experiences of being parented, and then negatively impact upon their children. This thesis critically evaluates attachment-based parenting interventions in the

context of BPD, as well as recently developed parenting interventions for BPD. It is argued that a mindfulness-based parenting intervention for BPD mothers would be beneficial for addressing emotion regulation and other difficulties experienced by mothers with BPD.

Chapter 6 features the development of a 'Mindful Parenting Group Intervention for Mothers with Borderline Personality Disorder Traits' (MPG-BPD) program, and provides a theoretical framework, a justification for developing a group intervention, the treatment approach and the program design. A brief overview of the program content is provided. The final section of this introductory section ends with a statement of the aims and hypotheses of this thesis. Chapter 7 describes the methods used including the recruitment, participants of the two group pilot programs and their attendance, followed by the program procedures and the measures used for the evaluation of program outcomes and processes.

The procedures and findings of both the quantitative and qualitative group analyses are outlined in chapter 8. Chapter 9 describes the case analysis procedure conducted in order to triangulate the quantitative and qualitative results. The results of this data triangulation are reported as case studies for each of the seven participants. Chapter 10 focuses on the program itself and reports the quantitative and qualitative participant feedback and evaluates the MPB-BPD program.

The major findings of the group, case study and program evaluation analyses are summarized and discussed in chapter 11, with recommendations made for future implementation of the MPG-BPD program. Methodological limitations of this study are discussed, and implications for advancing future treatment and research into parenting interventions for mothers with BPD are highlighted.

Chapter 2: Borderline Personality Disorder Diagnostic Features and Key Concepts

BPD is a chronic psychiatric condition that is characterised by instability in emotions, behaviour, interpersonal relationships, and self-concept. "People with BPD experience significant suffering and distress due to difficulties in relating to other people and the world around them" (National Health and Medical Research Council, 2013) and are at serious risk of suicide (Hooley, Cole, & Gironde, 2012). BPD is the most frequently diagnosed personality disorder (PD) (Rao, 2010b), with the diagnosis of BPD associated with considerable social stigma which can result in marginalisation by service providers and clinicians (Nehls, 1998; Rao, 2010b). As a result, patients with BPD can have difficulties gaining access to effective treatment and support services in Australia (Mental Health Council of Australia, Brain and Mind Institute, & Human Rights and Equal Opportunity Commission, 2005). They may be viewed as 'attention seekers' and 'trouble makers', and be considered as too problematic and 'untreatable' (Australian Parliament Senate Select Committee on Mental Health, 2006; Australian Parliament Senate Standing Committee on Community Affairs, 2008).

2.1 History of the Borderline Concept

The term 'borderline' has a controversial history and was first used in 1938 to describe a group of patients who did not appear to fit into the prevailing diagnostic categories and were considered to be on the borderline between 'psychosis' and 'neurosis' by some theorists (Kernberg, 1967; Schmideberg, 1947; Stern, 1938). 'Borderline' was also viewed as a form of schizophrenia until research in the late 1960s and 1970s began to redefine the borderline concept (Grinker, Werble, & Drye, 1968; Gunderson & Singer, 1975). BPD was first included as a mental disorder in the third

edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980 (American Psychiatric Association, 1980).

2.2 Clinical Features of BPD

The diagnosis of BPD is frequently controversial as there can be difficulties differentiating some of the clinical features from other comorbid disorders, as well as challenges related to unclear diagnostic boundaries, diagnostic stigma, and a perception that BPD is untreatable (Rao, 2010b).

In the DSM-III, BPD was conceptualised as a distinct PD and categorised as an Axis-II disorder with eight defining criteria, with an additional criterion included in the DSM-IV (American Psychiatric Association, 1980, 2000). In the recent publication of the DSM-5 the BPD criteria have remained unchanged, although the Axis-II category was removed (American Psychiatric Association, 2013). The DSM-5 diagnostic criteria for BPD are as follows:

> *A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:*
>
> 1. *Frantic efforts to avoid real or imagined abandonment.*
> 2. *A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation.*
> 3. *Identity disturbance: markedly and persistently unstable self-image or sense of self.*
> 4. *Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).*
> 5. *Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour.*
> 6. *Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).*

7. *Chronic feelings of emptiness.*
8. *Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).*
9. *Transient, stress-related paranoid ideation or severe dissociative symptoms.*

(American Psychiatric Association, 2013, p. 663)

2.3 Comorbidity

Diagnostic comorbidity is common for patients with BPD, as the frequency of comorbidity is related to the level of impairment and dysfunction experienced (Tomko, Trull, Wood, & Sher, 2014). In a 6 year follow-up study, Zanarini found that BPD patients demonstrated high rates of comorbidity as 75% met criteria for a mood disorder, 60% for an anxiety disorder, 34% for an eating disorder, and 19% for a substance use disorder (Zanarini, Frankenburg, Hennen, Reich, & Silk, 2004).

Bipolar disorder has a significant overlap with BPD as they share some important clinical features (including mood lability, impulsivity, unstable relationships, and suicidality) and "BPD is often misdiagnosed as bipolar disorder" (Rao, 2010b, p. 56). It has been demonstrated that 5% to 10% of BPD patients have a bipolar disorder diagnosis and 15% to 20% of bipolar disorder patients have BPD (Gunderson et al., 2006). Substance abuse has been found to occur in approximately 50% of BPD patients, which can impede the recovery of BPD and escalate the risk of suicide (Stone, 1990; Zanarini, Frankenburg, Hennen, Reich, & Silk, 2005). One study found nearly 90% of BPD patients to also have a diagnosis of at least one other PD (Conklin & Westen, 2005).

The co-occurrence of PTSD and BPD diagnoses have been found to be as high as 47% (McGlashan et al., 2000), as they share many symptoms which has led some clinicians to consider BPD as a form of complex PTSD (Herman, 1992; Herman, et al., 1989). However there are numerous instances of BPD developing without exposure to

traumatic events (Hooley, et al., 2012). On the other hand, it has been demonstrated that complex PTSD does not address the degree of emotional abuse, deprivation and neglect experienced by the majority of people with BPD (Zanarini, 2000; Zanarini, Frankenburg, Reich, & Marino, 2000; Zanarini, et al., 1997; Zanarini, et al., 2002), nor does it account for those with a trauma-free childhood.

2.4 Prevalence

The DSM-5 states that BPD "is diagnosed predominantly (about 75%) in females" (American Psychiatric Association, 2013). This is supported by a longitudinal clinical study in the United States of America (USA) that found 73% of the sample diagnosed with BPD were female, while 27% were male (Johnson et al., 2003). However, this 3:1 female to male gender ratio has been more recently disputed and may reflect sampling biases or higher rates of treatment seeking by women with BPD, as epidemiologic surveys have found no gender bias for BPD in the general population (Coid et al., 2009; Grant et al., 2008; Lenzenweger, Lane, Loranger, & Kessler, 2007; Torgersen, Kringlen, & Cramer, 2001). Although there have been few studies assessing the prevalence of PDs in Australia, early research estimates have indicated BPD has been diagnosed in approximately 1% of Australian adults (Jackson, 2000) and, based on British prevalence data (Coid, Yang, Tyrer, Roberts, & Ullrich, 2006; National Health and Medical Research Council, 2013), is estimated to have a prevalence of 3.5% for Australians aged 24-25 years. Consistent with other general population surveys, the Australian study (Jackson, 2000) found 52% of those with a BPD diagnosis were female and 48% were male.

International research has found BPD to be most prevalent in those aged below 30 and those from low income families (Tomko, et al., 2014). The prevalence of BPD

in the general community has been estimated at between 1% and 5.9%, with the prevalence in psychiatric populations found to be approximately 10-23% of outpatients and 20-43% of inpatients (American Psychiatric Association, 2013; Grant, et al., 2008; National Health and Medical Research Council, 2013; Rao, 2010b).

2.5 Prognosis

Although BPD has historically been considered to have a poor prognosis, over the past decade, studies have demonstrated that BPD prognosis is much better than previously thought. BPD symptoms tend to peak in early adulthood, with a pattern of chronic instability, impairment, and greater risk of suicide. Suicide rates for individuals with BPD are estimated to be between 3 - 10% (Leichsenring, Leibing, Kruse, New, & Leweke, 2011; Pompili, Girardi, Ruberto, & Tatarelli, 2005; Zanarini et al., 2008). Paris (2005a) found 90% of BPD patients improved despite multiple threats of suicide. The majority of individuals diagnosed with BPD tend to achieve increased stability in their 30s and 40s, and BPD symptoms decrease in older age (American Psychiatric Association, 2013).

Although the tendency towards intense emotions, impulsivity, and intense relationships is often lifelong, individuals who engage in therapeutic interventions often show initial improvement during the first year (American Psychiatric Association, 2013). The prognosis for individuals with BPD is good over the medium to long term. Longitudinal studies with 10-16 year follow-up have found that almost all people with BPD will eventually achieve symptomatic recovery, but may still experience impaired psychosocial functioning (Gunderson, Stout, McGlashan, & et al., 2011; Zanarini, Frankenburg, Reich, & Fitzmaurice, 2012).

2.6 Aetiology

The aetiology of BPD is complex, with childhood trauma considered a significant risk factor in the development of the disorder. A classic study by Herman, Perry, and van der Kolk (1989) found major childhood trauma was reported by the majority of BPD patients (71% physically abused, 68% sexually abused, and 62% witnessed serious domestic violence). More recent findings have demonstrated that people with BPD have experienced abuse more frequently than others, and multiple types of trauma that began earlier in childhood that were repeated over longer time periods (Bradley, et al., 2005; Zanarini, 2000; Zanarini, et al., 1997; Zanarini, et al., 2002). Zanarini et al. (1997) found that some form of childhood abuse was reported by 91% of a large cohort of BPD patients. Battle et al.'s (2004) study found 66% of BPD patients reported experiencing childhood emotional abuse by a carer, 44% reported physical abuse, and 18% reported sexual abuse. Furthermore, BPD symptom severity has been significantly associated with the severity of reported childhood abuse (Herman, et al., 1989; Zanarini, et al., 2002). Nineteen percent of BPD patients in Battle et al.'s (2004) study did not report a history of any form of childhood abuse, although 90% indicated experiences of childhood neglect. Despite the prevalence of abuse found in the childhood of people with BPD, not all abused children develop BPD and not all people with BPD have experienced abuse.

Neurobiological factors have been implicated in the development of BPD including lowered central serotonergic function (Rinne, Westenberg, den Boer, & van den Brink, 2000; Traskman-Bendz, Asberg, & Schalling, 1986), hyperactivity of the amygdala (Donegan et al., 2003; Herpertz et al., 2001), greater activation of the hypothalamic-pituitary-adrenal axis in response to stressful situations (Gunnar, Brodersen, Nachmias, Buss, & Rigatuso, 1996; Hertsgaard, 1995), and structural brain

abnormalities that include reduced volumes in the hippocampus, amygdala, orbitofrontal cortex, and anterior cingulate gyrus (Driessen et al., 2000; Nunes et al., 2009; Tebartz van Elst et al., 2003). While growing up in abusive and stressful circumstance has been found to affect these neurobiological structures and functioning (Glaser, 2000; Kaufman & Charney, 2001; Teicher, Anderson, & Polcari, 2012), it is difficult to apportion how much the level of functioning is due to environmental, compared to inherent biological factors.

Inherited temperament has been proposed as a factor in BPD aetiology, since BPD is characterised by high negative affectivity and impulsivity (Saulsman & Page, 2004; Widiger, 2005). Twin studies indicate that BPD may be genetically influenced (Bornovalova, Hicks, Iacono, & McGue, 2009; Reichborn-Kjennerud et al., 2015; Torgersen et al., 2000), and heritability estimates indicate a 4-20 times higher prevalence of BPD in relatives of patients with BPD (Hooley, et al., 2012). Although the genetic contribution may be a risk factor for BPD, a review of the literature indicates that early environment profoundly affects the development of personality and may have a greater influence on BPD aetiology than for other PDs (Torgensen, 2005). Environmental influences are theorised to explain the largest proportion (55%) of the variance of BPD traits (Hooley, et al., 2012).

Sociocultural factors may play a role in BPD aetiology, as BPD is proposed to be more prevalent in modern westernised societies (Paris, 1998). This may relate to strong roles and structures being provided in traditional societies, with the prescribed norms and social roles of such societies providing psychological ‘holding’ for people with a fragile sense of self and identity so that they are more able to function according to these norms (Millon, 2000). Traditional societies also tend to have greater contact with extended family, which could increase the possibility of alternative attachment

figures in childhood and an increased likelihood of neglect or abuse being witnessed which may lead to swifter intervention (Beatson, 2010; Millon, 2000).

It appears that there are numerous proposed risk factors for the development of BPD, including childhood abuse, neurobiological factors, temperament and sociocultural factors. Non-physically or sexually abusive childhood trauma can also be a significant risk factor for the later development of BPD. Weaver and Clum's (1993) study examined the developmental histories of a small sample of individuals with and without BPD to determine the relative contribution of traumatic experiences and family environment in predicting BPD symptoms. Sexual abuse was found to be a unique predictor of dimensional BPD score when other traumatic experiences were controlled for, as was high familial control. Family environment, parental psychopathology, and both childhood sexual abuse and physical abuse have been found to independently predict BPD symptom development (Bradley, et al., 2005). The study authors highlight the difficulty in distinguishing the relative contributions of these factors to BPD symptomatology, as childhood abuse typically occurs within a disturbed family environment.

People diagnosed with BPD have been found to frequently report prolonged separations from caregivers (especially mothers) and/or emotional neglect in childhood (Patrick, Hobson, Castle, Howard, & Maughan, 1994; Soloff & Millward, 1983; Zanarini, Gunderson, Marino, Schwartz, & Frankenburg, 1989). Zanarini et al.'s (1997) study also serves to highlight the importance of emotional neglect and lack of care for even the child's most basic needs. They found 92% of BPD patients reported experiencing physical or emotional neglect in childhood, which was significantly more common than Axis II controls. Not only was the care of the female caregiver important, but this study also demonstrated that significant predictors of a BPD diagnosis included

emotional denial by a male caregiver, in addition to inconsistent and neglectful treatment by a female caregiver.

The range of research findings suggests a multifactorial model of BPD aetiology, with attachment trauma and the subsequent impairment on self-regulation abilities indicated as a significant factor in the development of BPD.

Chapter 3: Attachment Organisation and Borderline Personality Disorder

3.1 Attachment Theory

Attachment theory provides a framework for understanding the interpersonal and intrapersonal problems in BPD. Bowlby (1973) theorised that people develop a set of expectations about relationships based on their early life experiences with caregivers, and that their 'internal working models' about interpersonal functioning shapes personality as well as future relationships. Attachment behaviours function to increase the proximity of the child to the attachment figure (Cassidy, 2008) and are organised into an 'attachment behavioural system', where children become attached regardless of whether the attachment figure is meeting their needs (Bowlby, 1969/1982). Attachment behaviours are organised according to the caregivers' style of response to requests for proximity, protection and comfort (Bowlby, 1969/1982, 1988).

Attachment theory emphasises the importance of mother-infant relationships based upon the bonds that develop in early caregiving experiences (Bowlby, 1980). Although most infants form attachments to more than one attachment figure, there tends to be a preferred primary attachment figure for comfort and security (Bowlby, 1969/1982). Research has demonstrated that most infants and toddlers tend to seek comfort from their mothers when distressed (Ainsworth, 1967; Lamb, 1976; Lamb, 1997; Umemura, Jacobvitz, Messina, & Hazen, 2013). As it would be most adaptive for a child to prefer the attachment figure who is most strongly bonded to them (Cassidy, 2008), this preference for the mother as the primary attachment figure may be related to the biological mother having the greatest parental investment in the child.

Bowlby asserted that "an individual's sense of safety and security is derived from *maintaining* a bond with an *accessible* and *responsive* caregiver" (Kobak & Madsen, 2008, p. 24). These attachment bonds depend upon the extent that the mother

provides her child with a secure and dependable base from which to explore the world, the amount of encouragement she provides to support exploration, and her ability to meet her child's need for comfort when love and care is sought. Bowlby (1973) considered emotions as essential regulatory mechanisms within attachment relationships, as for example an expression of distress can alert the attachment figure to the child's need for maintaining the attachment relationship. During infancy, the expression of positive and negative emotions within the attachment relationship can be considered as strategies to allow attachment needs to be met (Cassidy, 1994). When the attachment figure is reasonably sensitive and responsive in soothing the child when distressed or threatened, they assist the child to regain emotional equilibrium. Repeated caregiver-child interactions in emotion-laden contexts teach the child that particular strategies are more useful for reducing emotional arousal than others (Sroufe, 1996). These experiences become prototypes for patterns of self-regulation and the internal working models that guide the child's behaviour and emotion regulation strategies (Hofer, 1994). Through the experience of an attachment relationship in which distress is regularly followed by recovery, positive experiences are shared, and behaviour remains organised even during strong emotions, the child develops internal working models with an expectation that comfort can be sought from others when needed, and that others will respond with love and care. The child develops a sense of personal efficacy following the consistent success of having their needs met in response to their own actions. These 'secure' early attachment relationships result in outcomes that include positive expectations of others, self-confidence, self-regulation efficacy, and self-worth. Thus, the attachment relationship becomes internalised and influences the child's development of emotion regulation, interpersonal relationships, and self-concept (Bowlby, 1980; Sroufe, 2000).

3.2 Attachment Organisation

Ainsworth's Strange Situation procedure was developed as an empirical measure of child attachment security which involved a series of structured observations in a laboratory playroom of two mother-infant separations, one where the infant is with an unfamiliar female during the separation and one where the infant is at first alone and then briefly with the stranger before the mother's return. Based on observations of the child's response to the stress of separation from their mother, and most importantly the subsequent reunions, Ainsworth and collegues (Ainsworth & Wittig, 1969; Ainsworth, Blehar, Waters, & Wall, 1978) identified that most infants organised their attachment behaviours into three main attachment patterns. Infants classified as having a 'secure' attachment relationship use the mother as a secure base for exploration and at separation the infant may be overtly distressed and reduce their exploration. Secure infants may be friendly towards and somewhat comforted by the stranger, although there is an obvious preference for the mother's comfort. Upon reunion, the infant will seek proximity or contact with the mother, be readily comforted by the mother's attention, maintain contact with the mother for as long as is necessary, and then return to interacting with the environment. A securely attached infant will also have a positive response (e.g., smiling or initiating interaction) to the mother's return when not distressed. This attachment style occurs when an infant develops a mental representation of their attachment figure (usually the mother) as available and responsive to their needs.

Insecure attachment occurs when an infant is unable to develop this representation of their attachment figure (Cassidy, 2008). Infants classified as 'insecure avoidant' explore their environment with minimal reference to the mother and at separation appear minimally distressed. Avoidant infants tend to treat the stranger in a similar manner to the mother, although some may appear more responsive to the

stranger. Upon reunion, the infant will appear to ignore or avoid the mother and will make no effort to maintain contact with the mother. This attachment style usually occurs when the caregiver dismisses the infant's requests for protective attention and comfort, and the infant has learnt to expect rejection (Weinfield, Sroufe, Egeland, & Carlson, 2008). Infants classified as 'insecure resistant/ambivalent' demonstrate minimal exploration and seek proximity and contact with the mother even before separation occurs. These infants tend to be highly distressed by separation and not easily calmed by the stranger. Upon reunion, they may seek proximity or contact with the mother but will not be comforted by the mother's attention. Some resistant/ambivalent infants may fail to actively seek contact and continue to express distress during reunion episodes. This attachment style tends to be a result of insensitive, inconsistent caregiver responses to the infant's requests for attachment, often as a result of the caregiver misreading the infant's cues. This can involve a pattern of intrusiveness in the infant's exploration when attention is not desired, and when attention is sought there can be a lack of involvement in and encouragement of the infant's autonomous exploration of the environment (Cassidy, 1994; Weinfield, et al., 2008).

3.2.1 Attachment dysfunction.

As approximately 20% of infants' attachment patterns tended to be characterised by a lack of behavioural and attentional organisation in the Strange Situation procedure, they could not be reliably classified into these categories. Main and Solomon (1990) therefore introduced an additional classification of 'disorganised/disorientated'. This theorised disorganised attachment style entails contradictory behaviour patterns such as calling loudly for the mother when separated but then actively avoiding contact at

reunion, or approaching the mother with an averted head or gaze. Disorganised attachment may also be demonstrated by lack of orientation, frightened expression, or freezing behaviour (Main & Solomon, 1990). These behaviours are thought to represent a paradoxical attachment (approach-avoidance) dilemma, where the infant is unable to organise a consistent strategy toward the caregiver (often the mother), who is simultaneously perceived as a source of threat and a source of comfort and protection (Crandell, Patrick, & Hobson, 2003; Liotti, 2000; Lyons-Ruth, Bronfman, & Parsons, 1999; Madigan et al., 2006).

The disorganised attachment style has a demonstrated association with caregiver unresolved losses and traumas (Main & Hesse, 1990; Main & Morgan, 1996). It is posited that traumatic memories of a parent's own childhood may occur while caring for their own child, which can trigger an automatic expression of fear, which may be exacerbated by a fear of repeating the inadequate parenting behaviours they received. The infant will therefore frequently experience the caregiver's expression of fear, alongside expressions of frustration, anger and hurt (Main & Hesse, 1990). The expression of fear in an adult's face is frightening to an infant as it is interpreted as signalling danger and activates the defence system (Field & Fox, 1985; Main & Hesse, 1990). The automatic strategies of the defence system (flight, freezing, defensive aggression or submission) are considered to be in conflict with the safety system strategies of approaching, exploring or calming (attachment behaviour) (Liotti, 2014).

Additionally, a disorganised attachment style has been found to result from disrupted and contradictory caregiver responses to an infant's needs for comfort or abusive behaviour from a caregiver, which is frightening for the child who simultaneously perceives the caregiver as their only source of comfort (Carlson, Cicchetti, Barnett, & Braunwald, 1989; Lyons-Ruth, et al., 1999; van Ijzendoorn,

Schuengel, & Bakermans-Kranenburg, 1999). A disorganised attachment style may result in a perception of others as dangerous or ineffective, the world as threatening, and the self as not worthy of care. Disorganised attachment is a risk factor for internalising and externalising behaviour problems in early and later childhood (Carlson, 1998; Lyons-Ruth, Easterbrooks, & Cibelli, 1997; Lyons-Ruth & Jacobvitz, 1999; Moss, Rousseau, Parent, St-Laurent, & Saintonge, 1998), impaired metacognitive and mentalizing capacities (Green, Stanley, Smith, & Goldwyn, 1999), developmental psychopathology including oppositional defiant disorder, anxiety and mood disorders, ICD-10 disinhibited and reactive attachment disorders (Carlson, 1998; Green & Goldwyn, 2002; Lyons-Ruth & Jacobvitz, 1999; Teti, Messinger, Gelfand, & Isabella, 1995). Disorganised attachment has also been indicated as a risk factor for the development of dissociative disorders (Anderson & Alexander, 1996; Carlson, 1997; Coe, Dalenberg, Aransky, & Reto, 1995).

3.2.2 Emotion regulation.

As the attachment relationship is thought to influence emotion regulation via the child's internal working models of parent behaviour, there are differing strategies and patterns of emotion regulation that tend to develop from each attachment style. Children with a secure attachment style develop a belief that their emotional expression will be sensitively responded to, due to the secure attachment bond of emotional communication between the child and parent that has been developed from infancy. This emotional communication occurs when the parent is psychobiologically attuned to the dynamic shifts in the infant's internal states of arousal. The attuned parent evaluates the nonverbal expressions of arousal and regulates these affective states, while in moments of misattunement the parent is able to recognise the misattunement and

accurately reattune to regulate the infant's negative affective state. These processes of emotion regulation performed by others in infancy become increasingly self-regulated due to neurophysiological development (Schore & Schore, 2008). When experiencing negative affect their emotion regulation strategy involves open, direct and active expression to the parent. Securely attached children develop an ability to tolerate temporary negative affect in order to achieve mastery over frustrating or threatening situations (Cassidy, 1994). These children have developed the 'capacity to cope with stress' through the adaptable regulation of psychobiological states of emotions (Schore & Schore, 2008). Individuals with secure attachment organisation flexibly express the full emotional range in a manner that is context-appropriate and their regulatory strategies usually promote communication, compromise and relationship maintenance (Calkins & Hill, 2007; Schore & Schore, 2008).

It is theorised that the experience of consistent rejection by parents, particularly in times of distress, results in insecure avoidant attached children developing attachment deactivation strategies where emotional expression is restricted, particularly for negative affect because these emotions are associated with threats, vulnerability and emotional investment in a relationship (Ainsworth, et al., 1978; Malatesta et al., 1989; Mikulincer & Shaver, 2003). This functions to reduce the importance of the parent as a source of comfort and therefore minimizes the child's apparent need of the parent (Cassidy, 1994). Individuals with an insecure avoidant attachment style tend to have inhibited expression of emotions that are related to feelings of threat and vulnerability, with these strategies often resulting in a reduced awareness of their own emotional experience (Calkins & Hill, 2007). When experiencing increasing interpersonal stress these deactivating strategies tend to fail and result in the heightened activation of

feelings of insecurity, negative self-representations and increased internal distress (Mikulincer, Dolev, & Shaver, 2004).

It is posited that children with an insecure resistant/ambivalent attachment style may attempt to sustain and exaggerate negative emotions as a strategy to draw more attention from the attachment figure (Cassidy, 1994). As the attachment figure is often inconsistent in response, the child continues to seek more reliable support and protection through attachment hyperactivation strategies such as quickly forming inappropriate and intense attachments to others, and the heightening of emotion and extreme dependence (Main & Solomon, 1986; Mikulincer & Shaver, 2003; Mikulincer & Shaver, 2007). Therefore, insecure resistant/ambivalent attached individuals tend to overstate the presence and seriousness of threats and exaggerate their sense of vulnerability, become easily frustrated, and are overwhelmed by stress (Calkins & Hill, 2007; Sroufe, 2000).

As children with a disorganised attachment style are thought to experience recurrent activation of the attachment motivational system within confusing interpersonal contexts, they develop multiple, unstable and incompatible self-representations (Liotti, 2014). The disorganised pattern is associated with dissociative symptoms, entailing disruptions in environmental orientation and a failure to integrate various aspects of emotional and cognitive experience (Sroufe, 2000).

In the case of relational attachment trauma, danger emanates from the attachment relationship rather than the safety of having an attachment figure regulating the infant's negative affective states. This has significant consequences for the infant's brain maturation, which is experience dependent, throughout a critical period of development (Schore, 1994; Schore, 2000; Siegel, 1999). Early relational trauma has been implicated in the impaired development of the emotion processing limbic system,

particularly in the right brain hemisphere, which has been considered to be central in the "capacity to adapt to a rapidly changing environment" and in the "organisation of new learning" (Mesulam, 1998, p. 1028). This can result in a reduced capacity for processing socioemotional information and bodily states. The enduring developmental impairment of this system results in the individual being unable to adapt their responses to environmental demands and to self-regulate (Schore, 2001). Attachment trauma therefore interferes with the development of emotion recognition and regulation, as well as impulse control development.

This emotion regulation system deficiency is found in individuals with a disorganised attachment style, who tend to have deficits in identifying emotions as discrete mental states, labelling emotions, and lack understanding about the origin, function, and value of emotions (Linehan, 1993a). As disorganised children transition to preschool age, a developmental shift occurs where characteristic signs of conflict, apprehension, or helplessness in infancy often yield to a role reversal involving a range of controlling behaviours toward the parent. These disorganised attachment strategies have been associated with hostile aggression towards peers in preschool and to disruptive/aggressive disorders and dissociation vulnerability in adolescence (Carlson, 1998; Hesse & Main, 2000; Lyons-Ruth, 1996).

3.3 Adult Attachment

Attachment patterns in childhood are believed to influence personality development, and interpersonal and intrapersonal abilities. A secure attachment base allows a child to develop the ability to self-regulate emotions and impulses, manage interpersonal relationships, and establish a sense of self and identity (Bateman & Fonagy, 2004; Fonagy et al., 1995). Adult attachment has been categorically classified

into categories of secure/autonomous, preoccupied, dismissing, or unresolved, using the Adult Attachment Interview (Main, Kaplan, & Cassidy, 1985), a lengthy interview focused on parent-child relationships. Adult attachment has also been categorized into four prototypic styles derived from two underlying dimensions of *anxiety* and *avoidance* (Bartholomew & Horowitz, 1991; Brennan, Clark, & Shaver, 1998), which are measured by brief self-report methodologies that target adult-adult relationships. Research findings exploring the convergence of the AAI and self-report measures of adult attachment have not been consistent. Although the measures do not all converge on the same concepts or level of analysis, there is ample evidence that all are of value, are logically related to attachment theory, and are frequently related to each other (Mikulincer & Shaver, 2007).

A review of the literature has revealed good construct validity of self-report attachment measures for assessing the psychodynamics and interpersonal processes addressed by attachment theory (Shaver & Mikulincer, 2004). For the purposes of the current study, the four self-report attachment categories of secure, dismissive, preoccupied, and fearful were adopted.

Empirical investigation into adult attachment has found that individuals with a secure attachment style tend to have generally positive representational models of self and others with low anxiety about, and avoidance of, attachment needs and relationships. They tend to seek and rely on the support of others when experiencing stress and distress, as well as having self-soothing internalized representations of supportive attachment figures as an effective emotion regulation strategy (Mikulincer & Shaver, 2004). Adults with a dismissive style believe that support from others will not be available to them, and have low anxiety and high avoidance. They tend to have attachment deactivation strategies of inhibited support seeking and use distancing

strategies which contribute to detachment from relationships and emotional closeness (Mikulincer & Shaver, 2004; Mikulincer & Shaver, 2007). Individuals with a preoccupied style tend to have attachment hyperactivation strategies of amplified desire for interpersonal closeness, depending greatly on the approval of others, while at the same time lacking confidence that others will be reliably available and responsive to their needs (Mikulincer & Shaver, 2003; Mikulincer & Shaver, 2007). They have high anxiety and low avoidance, perceive themselves as lacking coping abilities, and are anxiously preoccupied with being rejected or abandoned (Collins, Guichard, Ford, & Feeney, 2004). Fearful individuals have a strong distrust of others with an intense fear and expectation of rejection. They are high in both anxiety about, and avoidance of, attachment needs and relationships. They tend to have difficulties trusting others and avoid intimate or close relationships (Collins, et al., 2004).

3.4 Attachment and BPD

Considering the frequency of attachment trauma reported by people with BPD, it is not surprising that disorganised attachment patterns in childhood have been proposed as a risk factor for the development of BPD (Fonagy, Gergely, Jurist, & Target, 2004; Holmes, 2003, 2004; Liotti, 2000). Numerous BPD attachment studies using interview and self-report measures have indicated that BPD and borderline traits are associated with the insecure attachment styles of fearful, unresolved, preoccupied and dismissive (Agrawal, Gunderson, Holmes, & Lyons-Ruth, 2004; Bateman & Fonagy, 2004; Levy, 2005).

Core features of BPD such as fear of abandonment, unstable and intense interpersonal relationships, unstable sense of self, feelings of emptiness, and anger outbursts, can be understood as a result of impaired attachment organisation (Fonagy et

al., 1996; Gunderson, 1996; Levy, Beeney, & Temes, 2011; Liotti, 2013; Yeomans & Levy, 2002). These researchers observed that impulsivity, affective instability, and self-damaging behaviours tend to occur in an interpersonal context, often following actual negative or negatively interpreted incidents in relationships.

3.4.1 Mentalization.

Over the past decade Fonagy and colleagues (e.g., Fonagy & Bateman, 2008; Fonagy & Bateman, 2005; Fonagy, Target, Gergely, Allen, & Bateman, 2003) have developed the theoretical concept of mentalization and identified BPD as a disorder characterised by a lack of mentalization. Mentalization is the ability to make sense of one's own and others' behaviour in terms of mental states such as thoughts, beliefs, and emotions (Fonagy, Target, Steele, & Steele, 1998). Reflective functioning (RF) is considered to be the psychological process that underlies the capacity to mentalize which involves self-reflection and interpersonal reflection, and allows the individual to distinguish between inner and outer reality (Fonagy, et al., 1998).

The capacity to mentalize is thought to develop as an outcome of attachment relationships, with mentalization acquisition occurring more rapidly in a secure attachment context, where caregivers' are able to accurately reflect or mirror the child's internal states from infancy (Bateman & Fonagy, 2004). Accurate mirroring of affect by the caregiver alongside coherent behavioural communication that represents to the infant that their internal states are manageable facilitates the early development of mentalization in the child. This process requires attunement, where the caregiver and child have the capacity to ready each other's cues and respond effectively. Attunement entails sensitivity to the child's expressed needs, awareness of the child's mental and emotional experiences, and the reflection and representation of these through responsive

behaviours such as comforting the child when distressed, feeding when hungry, and playing when feeling playful. This allows the child to feel understood by another and to develop an understanding of its own internal experience (Fonagy, 1991).

The child also looks to the caregiver for cues about how to respond to confusing or unfamiliar events. Having developed an ability to recognize the caregiver's emotional expressions from the mirroring of their own emotions, they become able to understand and respond to these occurrences. As the child becomes aware that others may have different thoughts and feelings to their own, they develop an understanding that their inner experience may not reflect external reality and that others in this external world have an inner world of their own (Taylor, 2012). This provides opportunities for the child to develop an understanding of self as perceived by the other, which leads to the exploration of their own psychological experiences. "This ability arguably underlies the capacities for affect regulation, impulse control, self-monitoring, and the experience of self-agency, the building blocks of the organisation of the self" (Fonagy & Target, 1997, p. 680); and hence mentalization is considered to be fundamental for establishing a sufficient sense of self.

Slade, Grienenberger, Bernbach, Levy, and Locker (2005) found adult attachment to be strongly related to maternal RF, where higher levels of parental reflective functioning (PRF) were found in securely attached mothers than in organised insecurely attached mothers, who in turn had higher PRF levels than the lowest levels of PRF found in disorganised insecurely attached mothers. It was also found that higher levels of PRF in these mothers was associated with secure attachment styles in their children, alongside lower levels of PRF associated with insecure attachment styles, and the lowest levels of PRF were associated with disorganised attachment styles in their children. These findings indicate that a mother's reflective capacities are related to her

own attachment context, impacting on the ability to attune to her child and her child's subsequent development of self and relationships with others, and the child's own attachment status. This study suggests that the capacity for reflectiveness regarding one's child may underlie the transmission of internal working models of attachment between generations.

Extending on this study, Grienenberger, Kelly, and Slade (2005) explored the relationship between maternal RF and maternal behaviour in the Strange Situation paradigm and mother's ability to regulate their infant's emotions. They demonstrated that the level of disruption in mother-infant affective communication was inversely related to the level of maternal RF; whereby highly reflective mothers were unlikely to demonstrate significant affective communication disruptions during the Strange Situation. These findings indicate that although RF is integral to the intergenerational transmission of attachment, the influence of maternal RF appears to be mediated through the mother's behaviour, specifically her capacity to regulate her child's distress and fear without frightening or otherwise affectively disrupting her child. Therefore, maternal RF can be viewed as critical for assisting mothers to provide integrated responses to infant's emotional distress.

Fonagy and colleagues consider RF to include "both a self-reflective and interpersonal component that ideally provides the individual with a well-developed capacity to distinguish inner from outer reality, pretend from 'real' modes of functioning, intrapersonal mental and emotional processes from interpersonal communications" (Fonagy, et al., 1998, p. 4). These distinctions are particularly important when parents are faced with their child's expression of intense negative affect. Parents who lack RF abilities can become easily dysregulated or disorganised by their child's distress as they are unable to distinguish between their own emotions and

those of their child. Thus, without the ability to pause and reflect on their child's distress, parents may be vulnerable to a range of negative representations in which they enact fearful and withdrawn, or hostile and intrusive responses in relation to their children. Fonagy and colleagues concluded from this perspective of PRF, that reflective capacity and its lack in parenting situations is the transgenerational mechanism that leads to the development of personality disorders. Thus their transgenerational model of BPD emphasizes the critical and essential role of reflective functioning

When a caregiver has a reflective stance that is an accurate representation of their child's inner experience, the child has the opportunity to find themselves in the other, and this representation becomes internalised to form mental models of the self, of how the child comes to understand their inner mental states including their emotions, beliefs, needs and motivations. Thus the core of one's self is the representation of how we were seen in early attachment relationship by our caregiver. The ability to consider the inner mental states of others develops from our own early experiences of caregivers having an accurate awareness and reflection of our inner mental states, which we then internalise and generalise to others, including the attachment figure (Fonagy, et al., 2004).

The insecure and disorganised attachment relationships often experienced by people with BPD, inhibit reflective abilities and the capacity to understand self and others. Reflective capacity is further impacted upon by the malicious intent of others, excessive stress in early childhood, or trauma, particularly attachment trauma (Fonagy & Bateman, 2008). The reflective capacity is not able to appropriately develop due to the representations of self that are internalised in such early childhood experiences with caregivers. When children are responded to with intensely negative affective responses, particularly involving abuse, there is a tendency to avoid contemplating the mental

states of the attachment figure as the recognition of an implied emotional state of fear or hatred in the attachment figure would force the child to consider their caregiver's wish to harm them and to perceive themselves as worthless or unlovable. Fonagy and colleagues have proposed that: "(a) individuals who experience early trauma may defensively inhibit their capacity to mentalize; and (b) some characteristics of personality disorder may be rooted in this inhibition" (Fonagy, et al., 2004, p. 346).

The development of such non-reflective internal working models has serious consequences for the individual's behaviours in subsequent attachment relationships. When parents lack RF abilities, they experience their child's experience of distress as their own and respond with negative affective behaviours. Thus the child's internal experience is not met with a reflection of external understanding and management, it remains unidentified and confusing, with the unmanaged affect producing further dysregulation (Fonagy, 2000). Therefore, parents with BPD who have RF deficits and disorganised attachment styles behave in ways that transfer their lack of RF capacity to their children who develop similar attachment behaviours.

According to Fonagy and Luyten (2009), the core features of BPD can be understood as reflecting impairments in different facets of mentalization. For example, identity disturbance can be a result of impaired self-other differentiation, and alongside affective instability and chronic emptiness can be related to having unreliable access to thoughts and feelings. When objectives are impeded by another, it appears intentionally harmful and can feel intolerable to individuals with BPD because their own perspective is experienced as universal. Self-harm and suicidal behaviours are attempts to obtain relief from experiences of overwhelming and intolerable emotion that is not understood and regulated. It has been demonstrated that individuals with BPD have significantly lower reflective functioning and therefore less mentalization capacity than people with

other psychiatric disorders (Fischer-Kern et al., 2010; Fonagy, et al., 1996; Levy et al., 2006). As insecure and disorganised attachment relationships in childhood impede reflective functioning and mentalization capacity, which can then be transmitted across generations, it appears that it would be of value to incorporate an attachment-based approach to a BPD parenting intervention.

Chapter 4: Treatment Approaches for Borderline Personality Disorder

4.1 Pharmacotherapy

Medications (antipsychotics, antidepressants, mood stabilisers and anxiolytics) are frequently prescribed for the management of BPD symptomatology, and often in high doses (Rao, 2010a). Polypharmacy is common practice, based on the notion that different medications are needed to treat different aspects of BPD (Bender et al., 2001; Zanarini, Frankenburg, Khera, & Bleichmar, 2001). This treatment approach can be problematic considering 25% of BPD patients contemplate suicide via the method of medication overdose (Makela, Moeller, Fullen, & Gunel, 2006). Medications have been found to be efficacious for managing coexisting disorders (Rao, 2010a), although it is unclear and disputed whether pharmacotherapy is effective for treating the core symptoms of BPD (Nose, Cipriani, Biancosino, Grassi, & Barbui, 2006). It has been found that medications can be useful for containing BPD crises and may facilitate the patient to better use psychotherapy (Zanarini, 2005). Although studies of medications have demonstrated significant clinical benefits, psychotherapy is still considered to be the 'gold standard' for the treatment of BPD (Rao, 2010a).

4.2 Psychotherapy

Prior to 2003, only two psychotherapeutic approaches had been found effective for BPD: dialectical behaviour therapy and mentalization-based therapy. In recent years, randomised controlled trials have demonstrated strong evidence for additional effective BPD treatments including: transference-focused therapy, schema-focused therapy, cognitive behaviour therapy, cognitive analytic therapy, and acceptance and

commitment therapy (Beatson & Rao, 2010). A review of relevant literature found common features that are shared by all evidence-based psychotherapies for BPD:

- *Recognition of the importance of the quality of the therapeutic relationship to the outcome of treatment.*
- *A focus on one or more of the core deficits of BPD – dysregulation of emotions, dysregulation of impulses or deficits in the development of self.*
- *A clear rationale for the psychotherapy.*
- *Clarity about the aims of treatment.*
- *Clarity about the techniques employed.*
- *A supportive environment for the treatment.*
- *Regular supervision for the therapists conducting the treatment. (Beatson & Rao, 2010, p. 129)*

4.2.1 Dialectical behaviour therapy.

In the 1990s Marsha Linehan developed dialectical behavioural therapy (DBT) which challenged the therapeutic pessimism regarding BPD treatment. DBT is based on the principle that "BPD is primarily a dysfunction of the emotion regulating system" (Linehan, 1993a, p. 42) and is focused on four primary behavioural targets: (1) decrease life-threatening suicidal and parasuicidal acts; (2) decrease therapy-interfering behaviours; (3) decrease quality of life interfering behaviours; and (4) increase behavioural skills (Linehan, 1993a; Linehan, Tutek, Heard, & Armstrong, 1994).

DBT is an effective treatment for BPD with demonstrated improvements in behavioural control, self-harm, and suicidal behaviours (Beatson & Rao, 2010; Kliem, Kröger, & Kosfelder, 2010). DBT includes cognitive behavioural components, focuses on acceptance and validation of behaviour in the moment, the dialectical process, and highlights the therapeutic relationship and therapy-interfering behaviours (Linehan, 1993a). The dialectical process involves a discourse where an initial proposition or thesis occurs, then a contradiction or antithesis, followed by the integration or synthesis

of these opposites, which constitutes the next thesis. This process repeats with each synthesis considered to represent growth and development at a higher level. For example, during disagreement in the therapeutic relationship, the BPD client tends to face the dilemma of deciding who is right and who is wrong, as it is difficult for the client to comprehend that both, or neither, can be right or wrong. In the dialectical process the therapist emphasises "I'm acceptable and you're acceptable". For instance, in the DBT strategy of observing limits, the therapist validates the client's point ("Yes, it would be better for you if I were not taking leave for the week") while simultaneously not giving in or changing their own behaviour ("And I'm still acceptable for not giving in to you and taking leave"). Through this process, DBT emphasises the value of the perspective of others and the idea that there is no absolute truth (Linehan, 1993a).

DBT involves 12 months of treatment with weekly individual cognitive-behavioural psychotherapy sessions, weekly skills-training groups, and telephone consultation at times of crisis (Linehan, 1993a). The skills training component of DBT includes teaching the 'core' skills of mindfulness, emotion regulation, and distress tolerance; with interpersonal effectiveness and behavioural self-management skills developing from these (Linehan, 1993b). BPD participants have been found to use at least some of the core skills prior to treatment about half the time, and through DBT the utilization and generalisation of these skills increase over time (Lindenboim, Comtois, & Linehan, 2007; Neacsiu, Rizvi, & Linehan, 2010; Stepp, Epler, Jahng, & Trull, 2008). Although effective for reducing BPD features, DBT can be problematic due to its length and cost (Paris, 2005b).

4.2.2 Mentalization-based treatment.

Mentalization-based treatment (MBT) was developed by Bateman and Fonagy and has been found effective for BPD in longitudinal studies (Bateman & Fonagy, 1999; Bateman & Fonagy, 2001, 2008a). MBT aims to enhance mentalizing capacity within interpersonal interactions via a therapeutic process whereby the therapist takes a mentalizing therapeutic stance, with a focus on the patient-therapist relationship during interventions designed to 'stress' the attachment relationship (Bateman & Fonagy, 2012). The objective is for the patient to develop an understanding of their current mental states in the present moment and how that influences their responses and actions. MBT is considered to consist of any intervention that succeeds "to reinstate mentalizing when it is lost or to help to maintain it in circumstances when it might be lost or is being lost…As a result of this, MBT takes a more permissive approach to interventions than most other therapies" (Bateman & Fonagy, 2010, p. 13).

MBT has been implemented as a day hospital program (MBT-DH) and as an intensive outpatient program (MBT-IOP), both consisting of a treatment phase and a maintenance phase, each lasting a maximum of 18 months. The treatment phase of MBT-DH involves partial-hospitalisation (five days per week) with daily group psychotherapy, weekly individual psychotherapy, art therapy twice a week, mentalizing cognitive therapy, writing therapy, and individual crisis management from a mentalizing perspective. The maintenance phase of MBT-DH consists of twice-weekly outpatient group therapy with the frequency reduced over time (Bales et al., 2012; Bateman & Fonagy, 1999). The treatment phase of MBT-IOP consists of weekly group psychotherapy, weekly individual psychotherapy, and individual crisis management from a mentalizing perspective. The maintenance phase of MBT-IOP involves individually tailored stepped-down care (Bateman & Fonagy, 2009).

An initial randomised control trial of MBT for BPD demonstrated significant and enduring improvements to mood and interpersonal functioning (Bateman & Fonagy, 1999; Bateman & Fonagy, 2001). Although mentalization was the common feature of all treatment elements, it was unclear whether it was the key component in effecting change. According to Bateman and Fonagy (2013):

> *The evidence base regarding the mechanism of change is relatively sparse. Although there is strong evidence supporting the mentalization focus of the therapy for patients with BPD, there is almost no evidence that a change in mentalization is brought about by the treatment. (p. 609).*

However, it is notable that at eight-year follow-up, the MBT group continued to have significant improvements compared to the control group, as only 13% of the MBT group continued to meet diagnostic criteria for BPD compared to 87% of the control group. Improvements were also demonstrated in impulsivity, interpersonal functioning and suicide rates (Bateman & Fonagy, 2008a). However, as with DBT, MBT appears to be a lengthy and intensive intervention.

4.2.3 Acceptance and commitment therapy.

Acceptance and Commitment Therapy (ACT) was developed by Hayes, Strosahl, and Wilson (1999), and has demonstrated efficacy as a treatment for a range of disorders (Twohig, 2012). ACT is a mindfulness-based therapy with a focus on values and psychological flexibility, considered part of the 'third-wave' of CBT (Ciarrochi & Bailey, 2008). ACT is based on the assumption that struggling against thoughts and feelings can increase symptoms, and therefore uses strategies such as mindfulness, acceptance, and cognitive defusion to change the individual's relationship to psychological events (Beatson & Rao, 2010). There is promising preliminary evidence supporting the use of ACT group treatment for BPD. Gratz and Gunderson (2006)

conducted a 14-session group intervention for self-harming women with BPD which focused on emotion dysregulation and included ACT interventions. Significant positive effects were found for BPD symptoms, self-harm, emotion dysregulation, experiential avoidance, depression, anxiety and stress. Morton, Snowdon, Gopold, and Guymer (2012) conducted a pilot study of 'Wise Choices', a 12 session ACT-based group intervention for public mental health clients with symptoms of BPD. Significant improvements were found in BPD symptoms, emotion regulation skills, mindfulness, psychological flexibility, fear of emotions, anxiety and hopelessness. An examination of mediators found that mindfulness, emotion regulation skills, and psychological flexibility predicted improvement in BPD symptoms. These findings are promising and indicate the potential efficacy of a BPD intervention involving a shorter treatment phase than DBT and MBT which is important when considering the economic cost involved for public mental health services with limited resources, or for the individual seeking private treatment (Watson, Rao, & Beatson, 2010).

The DBT and MBT treatments for BPD have well established efficacy, while ACT has demonstrated some promising initial results. DBT and ACT appear to have a focus on developing emotion regulation skills, while MBT has a focus on developing mentalization capacity. These three treatment approaches share many fundamental goals and common features, including a focus on increasing awareness. This is termed mindfulness in DBT and ACT, while MBT refers to this as reflective functioning or mentalization.

4.3 Mindfulness in BPD Treatment

4.3.1 Mindfulness.

Mindfulness is conceived as a state of mind characterised by an attentive awareness of the experience of the present moment in an accepting and non-judgemental manner, in which thoughts are viewed as mental events rather than as facts (Appel & Kim-Appel, 2009), with the individual learning "not to take her emotions and thoughts literally" (Linehan, 1993a, p. 145). Research has established five mindfulness skills that are representative of a higher order mindfulness factor (Carmody & Baer, 2008):

1. Observing
2. Describing
3. Acting with awareness
4. Nonreactivity to inner experience
5. Non-judging of inner experience

The therapeutic application of mindfulness involves a quality of mindful awareness that is characterised by non-judgment, acceptance and compassion (Germer, 2013), which are particularly important when treating individuals with overwhelming and traumatic experiences. Through mindfulness one can learn to be attentive to difficult emotions and thoughts in an 'observer' mode where internal experiences can be noticed and described without entanglement (Siegel, Germer, & Olendzki, 2009). Acceptance entails allowing our experience to be just as it is in the present moment. The acceptance of both pleasurable and painful experiences as they occur is a prerequisite to behaviour change (Germer, 2013), and self-acceptance is considered to be central to the therapy process (Brach, 2003; Linehan, 1993a; Rogers, 1961). Of added importance is a compassionate response to one's own pain, as well as to others

pain, when dealing with intense and unremitting emotions (Feldman & Kuyken, 2011; Germer, 2009). Such a compassionate approach can reduce self-criticism, negative self-appraisals and experiential avoidance, which are central in BPD (Batten, Orsillo, & Walser, 2006; Follette, Palm, & Pearson, 2006).

Mindfulness and mentalization can be easily confused due to overlapping concepts, which include the emphasis on the awareness of mental states and the reality they represent, as well as the non-judgmental stance of curiosity, acceptance and compassion. While mindfulness involves a present-moment focus and attentiveness to mental states in self and others, mentalization is differentiated by the construction of a biographical and autobiographical narrative, the reflection on the meaning of, and making inferences about, mental states (Allen & Fonagy, 2014).

4.3.2 Mindfulness-based interventions.

Mindfulness-based interventions have resulted in a variety of positive outcomes including reduced stress, anxiety and depression, as well as increased positive affect, improvements in well-being, and enhanced interpersonal relationship functioning (Astin, 1997; Baer, 2003; Carson, Carson, Gil, & Baucom, 2004; Kabat-Zinn, 2003; Segal, Williams, & Teasdale, 2002). Mindfulness-based interventions have been demonstrated as potentially beneficial for the treatment of a variety of disorders by breaking cycles of automatic cognitions and behaviour (Duncan, Coatsworth, & Greenberg, 2009). Additionally, increased mindfulness has been associated with improvements in behavioural self-regulation (Brown, Ryan, & Creswell, 2007) and self-control (i.e., reductions in substance abuse, self-mutilating behaviours, and parasuicidal attempts) in DBT interventions with BPD clients (Bohus et al., 2000; Koons et al.,

2001; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan et al., 1999; Verheul et al., 2003).

4.3.3 Mindfulness and borderline personality features.

Empirical studies have found mindfulness to be inversely related to BPD features (Fossati, Vigorelli Porro, Maffei, & Borroni, 2012; Wupperman, Neumann, Whitman, & Axelrod, 2009); and for women with BPD, higher levels of mindfulness have been associated with better emotional well-being (O'Toole, Diddy, & Kent, 2012). Similarly to the mentalization deficits thought to develop from attachment dysfunction, temperamental traits and childhood trauma have been implicated in the reduced mindfulness capabilities in BPD (Elices et al., 2015). In particular, low levels of mindfulness are associated with insecure attachment (Agrawal, et al., 2004; Wupperman, Neumann, & Axelrod, 2008), and mindfulness has been found to mediate the relationship between fearful/preoccupied attachment and BPD features (Fossati, Feeney, Maffei, & Borroni, 2011). More recently, Wupperman, Fickling, Klemanski, Berking, and Whitman (2013) reported preliminary findings that indicate mindfulness deficits mediate the relationship between BPD features and harmful dysregulated behaviour.

4.3.3.1 Current mindfulness-based interventions for BPD.

Emotion dysregulation has been found to be a core feature of BPD (Linehan, 1993a; McGlashan, Grilo, Sanislow, Ralevski, & et al., 2005), and DBT has demonstrated efficacy for improving emotion regulation skills which has been associated with mindfulness practice (Hölzel et al., 2011). The most frequently taught skills in the DBT skills training group are the ‘core’ mindfulness skills of observing,

describing, participating, taking a nonjudgmental stance, focusing on one thing in the moment, and being effective (Linehan, 1993b; Stepp, et al., 2008). Distress tolerance skills consist of crisis survival strategies and acceptance skills to develop a nonjudgmental acceptance of oneself and one's current situation. The application of mindfulness is also required for the emotion regulation skills of first identifying and labelling emotions, then identifying obstacles to changing emotions, reducing vulnerability to 'emotion mind', increasing positive emotional events, increasing mindfulness to current emotion, taking opposite action, and applying distress tolerance techniques (Linehan, 1993a). The most frequently practiced DBT skills have been found to be mindfulness followed by distress-tolerance (Lindenboim, et al., 2007; Stepp, et al., 2008), with increased mindfulness and emotion regulation skills associated with a significant reduction in the identity disturbance features of BPD (Stepp, et al., 2008).

The Wise Choices ACT group intervention for BPD (Morton & Shaw, 2012; Morton, et al., 2012) also has a practice of mindfulness skills and the adoption of a mindful way of functioning as central to treatment. This ACT group resulted in improved mindfulness as measured by the Five Factor Mindfulness Questionnaire (Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006) total score, which measures the facets of observing, describing, acting with awareness, nonjudging of inner experience, and nonreactivity towards inner experience). The Wise Choices BPD intervention also demonstrated efficacy for emotion regulation skills improvement, as measured by the Difficulties in Emotion Regulation Scale (Gratz & Roemer, 2004) total score, which assesses difficulties with strong emotions including nonacceptance of negative emotions, inability to engage in goal-directed behaviours when experiencing negative emotions, difficulties controlling impulsive behaviours when experiencing negative

emotions, limited access to emotion-regulation strategies perceived as effective, lack of emotional awareness, and lack of emotional clarity (Morton, et al., 2012). A preliminary outcomes study of an eight-session ACT-based parenting group for veterans with PTSD found improvements in positive parenting behaviours, parental satisfaction and psychological flexibility (Casselman & Pemberton, 2015).

Considering the relationship between mindfulness and BPD, it has been proposed that mindfulness may be an important component of effective BPD treatment (Fossati, et al., 2011; Wallin, 2007; Wupperman, et al., 2008). Furthermore, a mindful treatment approach that emphasises the practice of compassion towards the self and others may be particularly beneficial for mothers with BPD, as negative self-evaluations can result in the emotional reactivity feature of BPD (Gratz, Rosenthal, Tull, Lejuez, & Gunderson, 2010).

Chapter 5: Borderline Personality Disorder Parenting Interventions

5.1 Outcomes for Children of Mothers with BPD

Infants of mothers with BPD are a high-risk group for developing insecure and problematic attachment styles, which can affect their emotional and social development (Barnow, et al., 2006; Hobson, et al., 2005; Lamont, 2006). Additionally, it has been found that the children of mothers with BPD are exposed to higher levels of parental substance abuse and suicide attempts (Weiss, et al., 1996). It is therefore not surprising that children of mothers with BPD have been found to have more emotional and behavioural problems than other children, including lower levels of self-esteem, attention problems, delinquency and aggression (Barnow, et al., 2006).

Research has demonstrated that in comparison to children of mothers with other personality disorders, children with BPD mothers are more likely to experience family instability, removal from home, exposure to drug or alcohol abuse and the mother's suicide attempts (Feldman et al., 1995); as well as having higher rates of psychiatric diagnoses, including ADHD, disruptive behaviour disorders, and childhood borderline features (Weiss, et al., 1996). Furthermore, children of mothers with BPD have been found to have more anxiety, depression and low self-esteem than children of mothers with depressive disorders, cluster C personality disorders, and of mothers without any psychiatric condition (Barnow, et al., 2006). Of particular concern, was the finding that more than a quarter of the children of BPD mothers in Barnow, Spitzer, Grabe, Kessler, and Freyberger's (2006) study reported suicidal ideation. Indicative of the negative impact on children are the findings of a study by Macfie and Swan (2009) who investigated mother-child attachment relationships in children of mothers with BPD using story completion tasks. Compared to the control group, these children's narratives revealed poorer emotion regulation, more shameful and incongruent self-

representations, greater fear of abandonment, and parent-child relationships characterised by danger and/or unpredictability.

Recent longitudinal research (Barnow, et al., 2013) has found that maternal self-rated BPD symptoms predicted BPD features in offspring five years later, and that BPD symptoms are transmitted from mother to child even if subthreshold BPD symptoms were reported by the mother. Another recent study has also found that the transmission of borderline symptoms from mother to child to be mediated by insensitive, inappropriate or inconsistent mother-child interactions (Reinelt, et al., 2013). Considering the established negative developmental outcomes for the highly vulnerable children of mothers with BPD, it is clearly important to develop effective interventions to improve their psychological and behavioural outcomes.

5.2 BPD and Motherhood

Although the outcomes of children who have fathers with BPD is equally important, studies have tended to focus on mothers with BPD due to the unique mother-infant bond and the historical research findings regarding gender differences in the prevalence of the diagnosis (Lamont, 2006). Considering the environmental factors that contribute to attachment dysfunction and the development of BPD, it is unsurprising that women diagnosed with BPD experience a range of difficulties once they become mothers. They are likely to repeat parenting behaviours that were modelled to them in their childhood and to have difficulties developing a secure attachment relationship with their own child. These factors combined with BPD symptomatology are likely to result in mothers who find parenting particularly challenging and potentially overwhelming. Mothers with BPD have been found to have difficulties interpreting their infant's affect and to be inconsistently responsive to their needs (Bland, et al., 2004). These mothers are thought to have unresolved and traumatic attachment issues that can inhibit the

ability to be fully present and emotionally available to their own children (Lamont, 2006; Newman & Stevenson, 2005).

The reduced emotion regulation capacity of mothers with BPD can impede a mother's ability to cope with her child's emotional states (Newman & Stevenson, 2005; Paris, 1999). Mothers with BPD can often feel confused, anxious, overwhelmed, and alienated from their infants (Hobson, et al., 2005; Newman & Stevenson, 2005). These factors indicate that mothers with BPD have problems with maternal sensitivity, difficulties understanding and responding to their infant's emotional communication, and that their children are likely to develop emotion regulation deficits and insecure attachment styles.

5.2.1 Maternal sensitivity.

Maternal sensitivity, a mother's ability to accurately perceive and interpret her child's attachment signals and to respond to them promptly and appropriately, has been found to encourage the development of emotional regulation as well as attachment security in infants (Ainsworth, et al., 1978; Emde, 1980; Leerkes, Blankson, & O'Brien, 2009; McElwain & Booth-LaForce, 2006; van den Boom, 1994). Considering that patterns of attachment interactions are repeated from one generation to another (Benoit & Parker, 1994; Bowlby, 1980; Şen & Kavlak, 2012), it is likely that mothers with BPD will lack maternal sensitivity and repeat their own deficient attachment experiences in interactions with their infants. Recent research by Hobson, Patrick, Crandell, Garcia-Perez, and Lee (2005) provided strong evidence of this recapitulation of attachment patterns, as they found 80% of infants of mothers with BPD were categorised with disorganised attachment in the Strange Situation. The infants responded in ways that indicated that they did not expect their parent to return to soothe them after the

interpersonally stressful separation and other incidences of high stress (Crandell, et al., 2003).

Additionally, specific features of BPD such as impulsivity, affective instability, and anger control problems are likely to impact on maternal sensitivity. A study of mother-infant interactions indicated that mothers with BPD interact with their infants in an intrusively insensitive manner, and their infants were less responsive and appeared more dazed and depressed than normative comparisons (Crandell, et al., 2003). Furthermore, it has been found that mothers with BPD with children aged between 3-36 months were less sensitive, and their children were less interested and eager to interact with their mothers than normative comparisons (Newman, Stevenson, Bergman, & Boyce, 2007).

5.2.2 Parental reflective functioning.

Reflective functioning, the psychological process underlying mentalization, is proposed to develop through a process of having experienced oneself in the mind of another in early childhood, and requires a context of secure attachment to sufficiently mature (Bateman & Fonagy, 2003; Fonagy, Steele, Steele, Higgitt, & Target, 1994). Considering childhood attachment trauma has been found to disrupt the capacity to think about and identify mental states (Bateman & Fonagy, 2008b), it is not surprising that individuals with BPD have impairments in mentalization and therefore lessened reflective function capacity (Fonagy, Luyten, & Strathearn, 2011). Parental reflective functioning (PRF) refers to the parent's capacity for self-reflection and interpersonal reflection of cue, such as behaviour or context, to understand and interpret their own and their child's underlying mental states (Fonagy, Gergely, & Target, 2008; Slade, 2005). PRF impairments have been associated with BPD (Nijssens, Luyten, & Bales,

2013) and mothers with BPD have been found to have lesser mental state understanding of their 3-5 year old children compared to mothers without psychopathology (Schacht, 2013). The association of PRF with positive child development and the intergenerational transmission of attachment security (Ensink & Mayes, 2010; Slade, 2005) indicate that it is an important treatment consideration for mothers with BPD.

5.2.3 Mother's perception of self.

A mother's perception of her own competency is likely to impact upon the effort she invests into the mothering role (Bandura, 1996; Coleman & Karraker, 1998; Sanders & Woolley, 2005; Shumow & Lomax, 2002; Teti & Gelfand, 1991). This may result in limited parenting skills and negative self-evaluations which can subsequently impact on her child's development. As individuals with BPD tend to have a disturbance of identity characterised by an unstable sense of self, this insecure self-image may further impair the ability of a mother with BPD to perceive herself as a competent mother and effectively manage the everyday stresses involved in raising a child.

Research has demonstrated that there exists strong associations between self-concept and shame in women with BPD (a 'shame-prone' self-concept) (Rüsch, Lieb, Göttler, Hermann, & et al., 2007), and it has been proposed that by growing up in an environment where one is shamed for showing emotional vulnerability, individuals with BPD therefore respond to overwhelming negative affect with shame (Crowe, 2004; Linehan, 1993a). This shame-prone self-concept has also been found in girls with high levels of borderline personality features during middle childhood/early adolescence (Hawes, Helyer, Herlianto, & Willing, 2013). Shame has been implicated in the development of BPD symptoms including identity disturbance, affective instability and impulsivity, a sense of emptiness, dissociation, self-harm and suicidality (Crowe, 2004;

Fonagy & Target, 2000; Fonagy, Target, Gergely, Bateman, & Allen, 2003; Kaufman, 1989). It appears that this shame response could be a distinctive characteristic for women with BPD and such a shame-prone self-concept would likely impact negatively upon their self-image as a mother.

The reduced coping abilities in mothers with BPD are likely to result in high levels of stress, which attachment theory proposes will impinge on a mother's ability to be emotionally available to, and develop a secure attachment with, her child (Newman, 2008). Furthermore, the more stressed a mother perceives herself to be, the less competent she is likely to feel. In addition, self-efficacy beliefs may also be influenced by how successfully a mother is coping with her own psychopathology (Bandura, 1996; Fox & Gelfand, 1994; Jackson & Huang, 2000; Muzik et al., 2015). Such negative self-perceptions would be important to address in any BPD treatment due to the impact these can have on their children. This is particularly so for interventions that targets mothers with BPD.

5.3 Parenting Interventions

Although there are several effective treatments for BPD as well as numerous effective parenting interventions, these are typically distinct and not integrated. Surprisingly few interventions addressing maternal BPD and parenting have been developed and studied. This poses a problematic situation for mothers with BPD, as standard parenting interventions may not be able to address the unique needs of mothers with BPD, and typical BPD treatments do not usually address parenting problems.

5.3.1 Attachment-based interventions.

Considering the influence of attachment interactions in the developmental trajectory of children, it seems likely that attachment-based interventions directed at mothers with BPD could enhance attachment patterns and result in improved mother-child relationships and children's developmental outcomes. Evidence supports the efficacy of attachment-based interventions for increasing maternal sensitivity (Van Ijzendoorn, Juffer, & Duyvesteyn, 1995), parental reflective functioning (Suchman et al., 2010), and improving attachment security (Cicchetti, Toth, & Rogosch, 1999; Hoffman, Marvin, Cooper, & Powell, 2006). However, few studies have investigated such attachment-based interventions for mothers with BPD.

Attachment-based interventions tend to approach the prevention of insecure and disorganised attachment style transmission from a parent (usually the mother) to their child, through either individual psychotherapy with the mother or within the mother-child dyad. According to the attachment 'transmission model', a parent's internal working model of attachment directs their interpretation of and response to their child's needs, which then influences the child's attachment relationship with their parent (Van IJzendoorn, 1995). "Interventions designed with the parent as the primary patient aim to provide 'corrective' attachment experiences through interactions and experiences with the therapist" (Stepp, et al., 2012, p. 83). Individual psychotherapy aims to develop the mother's insight into the effect her past experiences have on her current functioning, her interpersonal style, and her current representation of her child (Stevenson & Meares, 1992). Child-parent relationship focused psychotherapy often involves observations of mother-child interactions that are recorded and then reviewed with the mother, and focuses on developing an understanding within the mother of how

her attachment patterns developed in her family of origin and impact on her current relationship with her child (Newman & Stevenson, 2008; Stepp, et al., 2012).

An intervention framework based on the Attachment, Self-Regulation and Competency (ARC) model (Kinniburgh, Blaustein, Spinazzola, & van der Kolk, 2005) was developed in the USA to provide a flexible, component-based intervention for children and families who have experienced complex trauma, a common experience of mothers with BPD. ARC addresses vulnerabilities formed by exposure to overwhelming life circumstances that inhibit healthy development and focuses on three core domains impacted by chronic interpersonal trauma: attachment, self-regulation (the ability to identify, modulate, and express internal experience), and developmental competencies. The attachment domain entails developing the caregiver's ability to identify and regulate emotions, respond consistently and appropriately to the child's behaviour, identify routines for the promotion of the child's sense of safety and self-regulation, and improving the capacity of the caregiver and child to read each other's cues. The self-regulation domain involves developing the child's emotion management strategies, emotional language, and understanding of the relationship between emotions and their triggers, as well as providing psychological safety for emotion communication. The developmental competencies domain entails developing the child's abilities for problem solving, anticipation and planning, and developing a sense of self that incorporates past and present experiences (Arvidson et al., 2011). An independent evaluation of ARC over six months with children aged 6 to 18 years found significant reductions in PTSD symptoms and overall Child Behaviour Checklist (CBCL) (Achenbach, 2001) scores (ICF International, 2010). An Alaskan evaluation of children aged 3 to 12 years found children completing ARC treatment had reduced

CBCL (Achenbach, 2000, 2001) total scores and 92% achieved placement permanency compared to a less than 40% annual permanency rate for Alaska overall (Arvidson, et al., 2011). Although the ARC model addresses the parent-child attachment relationship, maternal sensitivity, and caregiver affect management within a trauma context, the focus is on the child and it does not address potentially unresolved and traumatic attachment issues that caregivers may have.

Another USA based program with an attachment focus also targeted mothers and children who had experienced domestic trauma. The Child-Parent Psychotherapy (CPP) attachment-based intervention was evaluated in San Francisco for preschool children who had witnessed marital violence and abuse of their mothers (Lieberman, Van Horn, & Ippen, 2005). The mothers reported maternal childhood trauma including physical abuse, witnessing marital violence, and sexual molestation, which are frequently reported in the childhood histories of those with BPD. The children had also experienced multiple stressors including exposure to community violence, physical abuse, and sexual abuse. Thirty-six participants attended weekly 60-minute parent-child therapy sessions for 50 weeks of CPP, with individual sessions for mothers as clinically indicated. A further 29 received case management plus individual treatment. In this program, therapists observe and assess mother-child interactions and provide information about the impact the mother's past dysfunctional relationship experiences have on the current relationship with their child. The intervention has a direct focus on traumatic events, involving mother-child interaction and child free play with toys to elicit trauma and social interaction. The sessions target maladaptive behaviours, developmentally appropriate interactions, and work toward a shared trauma narrative and resolution of traumatic events. CPP addresses the following domains of functioning in the mother-child relationship: "play; sensorimotor disorganisation and

disruption of biological rhythms; fearfulness; reckless, self-endangering, and accident-prone behaviour; aggression; punitive and critical parenting; and the relationship with the perpetrator of the violence and/or absent father". (Lieberman, et al., 2005, p. 1242) The intervention has a focus on promoting child mental health through a relational process with increased maternal responsiveness to the child's developmental needs in order to enhance the child's trust in their mother's ability to provide protective care.

Children in the CPP group improved significantly in behavioural problems and traumatic stress disorder symptoms compared to the control group. This was attributed to the CPP focus on increasing maternal responsiveness to the child's developmental needs. Additionally, the CPP mothers demonstrated significantly fewer PSTD avoidance symptoms than controls. Lieberman, Van Horn, and Ippen (2005) indicated that this was a surprising outcome "because CPP does not target adult symptoms for intervention" (p. 1246) and theorised that this may be accounted for by the significant impact of the mother-child relationship on the psychological health of both children and mothers. Considering BPD symptomatology, a CPP intervention may not be sufficient to address the numerous parenting difficulties experienced by BPD mothers. The authors noted that their findings are limited due to the small sample size. Additionally, this approach of individual therapy is difficult to evaluate as it "has not been well manualised, which has impeded dissemination and evaluation efforts" (Stepp, et al., 2012, p. 83). There are however, a number of group interventions that attempt to improve the attachment relationships between at-risk mothers and their young children.

The Circle of Security (COS) intervention was developed in the USA to provide parent education and psychotherapy to at-risk populations. The COS intervention is based on attachment theory with a focus on maternal sensitivity and involves individualized treatment plans and 20 weekly sessions for caregivers (Hoffman, et al.,

2006). The sessions comprise of a small group of five to six caregivers using video vignettes of the parent-child dyads with related psychoeducational and therapeutic discussions. Key concepts of attachment theory are demonstrated to parents using video clips of their children in order to enhance their observational skills and promote reflection on their child's emotional needs. Each parent's caregiving strategies are demonstrated through video vignettes that are evaluated within the group based upon an underlying assumption that "every parent is more comfortable with some areas of parenting and less comfortable with others" (Marvin, Cooper, Hoffman, & Powell, 2002, p. 117). The parents are engaged in reflective dialogues about their 'under-used capacities/points of struggle' with a focus on parent and child emotion regulation. Successes and changes are later reviewed and celebrated using video vignettes of parent-child dyads (Marvin, et al., 2002).

The initial protocol-development study found that 69% of preschool children classified as disorganised prior to the intervention were classified with an organized attachment style post-intervention, with approximately 63% of those shifting to a secure classification. An at-risk sample of pregnant women in a jail-diversion program with a history of substance use participated in the COS Perinatal Protocol (Cooper, Hoffman, & Powell, 2003) which is derived from the COS protocol and involves attending group sessions twice weekly for 15 months from the third trimester of pregnancy (Cassidy et al., 2010). The results indicated that the infants' attachment classifications were comparable to those in low-risk samples, levels of maternal sensitivity were comparable to those in a community sample, and maternal depression had improved. The authors noted that due to the program's multiple treatment methods, it could not be determined whether the outcomes were due to the COS or other factors. An evaluation of the COS-Parenting Program (Cooper, Hoffman, & Powell, 2009), a condensed version of the

COS intervention, was conducted over nine weekly group sessions with mothers in a residential substance abuse treatment program. Nine of the 15 participants attended the majority of sessions and these participants demonstrated improvements in emotion regulation, parental attributions and discipline practices (Horton & Murray, 2015). An ongoing randomized controlled trial of the COS intervention is being conducted in Germany for mothers with mental disorders to determine the specific effects that promote attachment security in infants of mentally ill mothers. Although COS interventions address maternal sensitivity so that mothers can better attune to their child and meet their attachment needs, they do not address symptomatology or attachment issues that mothers with BPD tend to experience.

5.3.1.1 Watch, wait and wonder.

In Australia, Newman and Stevenson (2008) implemented an attachment-based psychotherapy intervention known as Watch, Wait and Wonder (WWW), originally developed in Canada (Muir, Lojkasek, & Cohen, 1999), for mothers diagnosed with BPD. The program was developed to enhance a mother's ability to observe and reflect on her infant's behavioural cues with a goal of improving maternal sensitivity and reflective functioning; and demonstrated promising initial efficacy with high-risk mothers (Cohen, Lojkasek, Muir, Muir, & Parker, 2002; Cohen et al., 1999). The intervention involves mother-child sessions with the mother observing and participating in child-led activities and then reflecting on their child's communication with the therapist. WWW was described to the mothers as an approach for improving their interactions and relationship with their child. Although this program was not developed specifically for mothers with BPD, it was offered as part of a larger study exploring parenting issues within this population (Newman, et al., 2007).

Newman and Stevenson (2008) acknowledged the limitations of the small sample size of six mothers diagnosed with BPD, but also highlighted the tendency for mothers with BPD to experience difficulties with commitment to therapeutic relationships and appointment attendance. Due to the propensity for erratic therapy attendance, the program aimed for mothers to attend 12-14 sessions with their infant within a five-month period, rather than arranging potentially unfeasible weekly sessions. This approach was reported to be "generally" successful and without continuity problems, although attendance rates and outcomes were not reported.

The authors noted that a theme emerged whereby the mothers tended to talk about their own issues rather than engaging in activities with their child, and it was necessary for the mothers to be repeatedly reminded to bring their infant with them to the sessions. It was observed that some of the mothers' appeared bored and had difficulty tolerating being present with their child. Some mothers expressed that the resentment they experienced about playing with their child was related to the neglectful parenting they had experienced in their own childhood, and on occasion this was observed to be re-enacted in the mother-child interactions. It was identified that a limited capacity for reflection was displayed by the mothers regarding their own and their children's behaviour, as it was observed that the mothers had difficulty reflecting on the meaning of behaviours. Several issues and recommendations were identified by the authors for consideration when implementing interventions with mothers with BPD:

1. An awareness of the complex issues brought to therapy by traumatised parents.
2. Provision of a safe holding environment to contain the anxiety and distress experienced by mothers with BPD and ensuring they do not feel dismissed.

3. Adherence to the goal of therapy - to support mothers to develop their reflective capacity towards their child in order to promote attachment organisation and security.

Although the WWW intervention was not modified specifically for BPD mothers, it identified BPD-specific issues that can arise for these mothers in an attachment-based intervention. It is notable that the majority of these appear to be associated with the child-focused nature of the intervention. This is a useful starting point for the exploration of much needed parenting interventions for mothers with BPD, and highlights the importance of further research into parenting interventions that address children's attachment needs while also focusing on the concerns of BPD mothers. This may be addressed through an intervention program that is designed for mothers to participate in without their child.

In sum, attachment-based parenting interventions often focus on the mother-child dyad and record mother-child interactions to increase the mother's awareness and understanding of their own attachment patterns and their child's attachment needs. This allows mothers to practice reflectiveness in the context of the mother-child relationship and to recognise the effect of past experiences on their current behaviours and relationships. The therapeutic relationship functions to provide psychological 'holding' and modelling of secure attachment behaviours. Attachment-based interventions have demonstrated efficacy for improving attachment security in high-risk mother-child relationships, as well as improving child behavioural problems, maternal sensitivity, parenting behaviours and parent psychological symptoms. However, as these interventions frequently involve the child in the therapeutic process, the primary focus is the child's needs and therefore may not sufficiently address potentially unresolved

and traumatic attachment issues that mothers may have. Thus, despite the value of attachment-based parenting programs, as a standalone intervention these may not be sufficient to address the needs of BPD mothers. "There appears to be a gap between the objectives of attachment-based interventions and the goals of mothers with BPD when they seek professional help" (Stepp, et al., 2012, p. 84).

5.4 Interventions Targeted at Mothers with BPD

Stepp et al.'s (2012) review of recommended interventions for mothers with BPD consisted of attachment-based interventions and interventions that have a component of family psychoeducation. Based on this review, Stepp et al. recommended treatments that include psychoeducation regarding childhood development and needs, parent-skills training, and mindfulness-based parenting strategies to enhance self-awareness and objectivity in difficult parenting situations; especially when the child is experiencing strong emotions or eliciting strong emotions in the mother. Although there has been a lack of specifically targeted parenting interventions for BPD mothers, recent developments in the area of parenting intervention for mothers with BPD indicate that the gap in this field of treatment is now beginning to be addressed.

5.4.1 Personality disorder parenting intervention.

An Australian parenting intervention has been developed to address this treatment need based upon the Project Air Strategy for Personality Disorders (Project Air Strategy for Personality Disorders, 2015c). The Project Air Strategy was developed to augment treatment options for individuals with PDs incorporating an interpersonal focus. A brief intervention approach was used in order to address the high clinical demand from this population, as well as the lengthy waiting lists for longer-term

treatments (Greyner, 2014). A pilot study of the Project Air Strategy for Personality Disorders has found significantly reduced inpatient admissions, inpatient stays, and emergency department presentations. Twelve-month follow-up clinical interviews revealed that most clients' BPD symptoms had decreased from at least seven symptoms to four, depression symptoms and suicidal thoughts were significantly reduced, and there was a significant increase in quality of life ratings.

The Project Air Strategy Parenting Program was developed to enhance parenting interventions for parents with a PD to improve parent-child interactions and parental self-confidence (Greyner, 2014). The three session parenting intervention is flexible and can vary in the targeted parenting issues and intensity, with further sessions to work on the Project Air Strategy Parenting Program principles if deemed appropriate. The Parenting with Personality Disorder Intervention (Project Air Strategy for Personality Disorders, 2015a) is administered in three phases: 1) Engaging the parent and reinforcing safety for all, 2) Ways to separate parenting from personality disorder, 3) Communication and relationships. The intervention includes key parenting messages about safety, being a 'good enough' parent, separating parenting from personality disorder, children's needs and feelings, spending enjoyable time together, parent-child relationship reflection and skill development, the importance of mental health treatment, and the role of self-care and self-compassion in parenting. The Parenting with Personality Disorder Intervention has not yet published an outcome evaluation study; although an overview of the Project Air Strategy Parenting Program indicated that 95% of NSW Health staff working with parents with personality disorder provided feedback that the training was helpful in improving treatment (Project Air Strategy for Personality Disorders, 2015b).

Although the program targets parents with a PD it is unclear whether it has been specifically developed for parents with BPD. However, as BPD is the predominant PD diagnosis (Rao, 2010b), the program is likely to address some BPD-specific difficulties. Furthermore, as the program does not specifically target mothers, it may be limited in addressing the particular issues experienced by mothers with BPD. As the program outcomes are yet to be published, it is yet to be determined whether such a brief intervention is sufficient to improve mental health outcomes for parents with a PD and their children, and whether outcomes would be maintained over time. Despite these limitations, the development of the Parenting with Personality Disorder intervention indicates an encouraging treatment response to the recommendations made by the Australian clinical practice guidelines for the management of BPD, and provides a valuable contribution to research in this area.

5.4.2 Group interventions for mothers with BPD.

Similar to the advantages of a reduced treatment duration outlined by Greyner (2014), a group intervention can increase treatment accessibility, provide treatment to a greater number of people in need, and reduce waiting lists and expenses. Further, group therapy can be advantageous due to the curative factors described by Yalom and Leszcz (2005) such as universality, giving and receiving emotional support, modelling, bonding, sense of belonging, increased awareness of interpersonal behaviour, practicing interpersonal skills, and improved self-confidence from the experience of being helpful to others. These factors seem especially important for addressing the difficulties experienced by mothers with BPD.

Two group programs targeting parents with BPD are being developed, although initial steps regarding group interventions were first made in 1985, where a group

program was developed for mothers with BPD and their toddlers aged between 12 and 36 months (Holman, 1985). The intervention involved a group for mothers focused on difficulties with emotional separation-individuation and ego strengthening, and a toddler group focused on promoting social interests and skills. The intervention aimed to improve maternal functioning via improvements in ego functioning that would potentially develop through the group process. Although the study indicated some improvement in mother-child interactions, these findings were based on general observations and were limited due to a lack of operationalised empirical measurement. However, this seems to be the first attempt at developing a group program targeting the unique difficulties experienced by mothers with BPD, and it appears that almost 30 years passed before another group intervention was designed specifically to address the parenting issues of BPD.

5.4.3 MBT for parents.

More recently, a variant of mentalization-based treatment for parents (MBT-P) with BPD and their children aged 0-4 years was developed by Nijssens, Luyten, and Bales (2013) and was piloted in the Netherlands. The program addresses parenting and the parent-child relationship, with a focus on enhancing the PRF capacity rather than concentrating directly on the child. MBT-P combines an existing intensive outpatient MBT for adult BPD patients (MBT-IOP) and a parent-infant module. MBT-IOP involves individual and group psychotherapy focused on mentalizing in relationships, although not specifically in the parent-infant relationship. The parent-infant module focuses on PRF and is conducted by different therapists. Over the course of two months the parent attends six group sessions of mentalization psychoeducation and training, and they bring their child to individual parent-infant therapy sessions once every two weeks.

MBT-P is a module of MBT-IOP in which participants attend twice-weekly group sessions and once weekly individual sessions. Considering the maximum 18-month treatment length of MBT, it seems that participation in the MBT-P module would require parents with BPD to attend a lengthy and intensive program. This may present an obstacle for the treatment of mothers with BPD who may have attendance difficulties due to caring for a young child in addition to difficulties committing to a therapeutic relationship (Newman & Stevenson, 2008).

As a program effectiveness study has not yet been published, Nijssens et al. stated that "based on our first experiences with MBT-P, the treatment program seems promising, but further research is definitely needed to substantiate these impressions" (2013, p. 94). It is unclear whether the particular difficulties experienced by mothers with BPD can be sufficiently addressed by a module designed for males and females that targets parental reflective functioning. Considering research indicates that a mentalization-based parenting program is effective for developing reflective parenting skills in high-risk first-time parents (Sadler, Slade, & Mayes, 2006) and the demonstrated efficacy of MBT for BPD, it seems likely that an intervention addressing PRF would be beneficial for mothers with BPD as well as for their children.

5.4.4 Parent-child DBT.

The present study is consistent with Zalewski, Stepp, Whalen, and Scott (2015) who identified that "to date, there is no empirical data testing the effectiveness of integrating parenting interventions with existing adult psychiatric treatment for BPD" (p. 73). They consequently used a qualitative methodology to gather information to inform the development of a treatment that incorporates parenting interventions into existing DBT treatments. The study investigated the parenting experiences of 23

mothers diagnosed with BPD who were participating in psychiatric DBT treatment entailing skills training, individual therapy and weekly psychiatric appointments. They also explored the mothers' preferences and suggestions for a parent-child DBT (PC-DBT) treatment program that was under development in the USA. The main experiences that emerged from interviews with the mothers were: Concerns about whether to and/or how to communicate with their child about their diagnosis, the impact their BPD had on their children (in terms of shared traits, role changes/reversal, and emotion dysregulation), guilt/worry/uncertainty about their parenting, and parenting feeling like a burden. When exploring the mothers' perspectives about a PC-DBT program, mothers typically indicated a preference for a group exclusively for mothers so that parenting topics could be focused on. The potential benefit of increased parenting confidence emerged as a theme, and a potential barrier of fear of being judged for their parenting behaviours was identified. Additionally, some mothers expressed concern about bringing their children to a group where other mothers' behaviours could be distressing and, where information disclosed may not be within their values, or about the influence of other children in the group.

Zalewski et al. (2015) noted a number of limitations in their study that included a lack of diagnostic assessment for BPD diagnosis (although the participants were recruited from hospital programs primarily treating BPD, with the majority of participants scoring above the clinical cut-off for BPD symptoms on a self-report measure). The authors also noted the variability in mothers' attendance in DBT-informed treatment that affected treatment impact, the uncontrolled effects stemming from the children's ages ranging from infancy to adulthood, as well as the lack of a comparison group. Despite these limitations, Zalewski et al.'s study (2015) draws attention to the unique concerns and difficulties experienced by mothers diagnosed with

BPD and suggests a potentially promising integration of BPD treatment and parenting principles to address this existing treatment gap.

Although limited parenting interventions for mothers with BPD have been researched, preliminary studies indicate the potential efficacy of an attachment-based reflective functioning intervention. Reflective parenting programs have a primary aim to develop a reflective stance in parents, i.e., to engage parents in thinking about their children in terms of the child's internal experience rather than their behaviour (Goyette-Ewing et al., 2003; Sadler, et al., 2006; Slade, 2006). For example, a mentalization-based home visiting parenting program 'Minding the Baby' (Sadler, et al., 2006) was developed to increase parental reflective functioning for high-risk first-time mothers (the sample included multiethnic, socioeconomically disadvantaged mothers aged 14 to 25), and was based on infant-parent psychotherapy and nurse home visiting interventions. Outcomes included significantly lower rates of disrupted mother-infant interactions, a higher likelihood of infant attachment security and a lesser likelihood of disorganised attachment compared to controls, and significantly increased parental reflective functioning as assessed by interview measures (Sadler et al., 2013). Despite these improvements, such reflective functioning programs are unlikely to address the numerous BPD-specific symptoms and parenting difficulties experienced by mothers with BPD. This thesis therefore argues that an effective parenting program would incorporate components of BPD-specific treatment such as mindfulness, attachment-based interventions, reflective functioning interventions, and psychoeducation.

5.5 Mindful Parenting

A mindful approach to parenting has also been advocated as a method for promoting secure attachment relationships (Siegel & Hartzell, 2003). Mindful parenting has been proposed as an approach to enhance mentalization in parents and their children (Reynolds, 2003). Mindful parenting may improve the parent-child relationship by increasing the parent's attention towards their own inner cognitions and feelings, which would also help them to develop an expanded awareness of their child's inner experience. Therefore, it seems likely that a mindful parenting approach would be beneficial for mothers with BPD.

Mindfulness when applied to parenting is more than simply the practice of mindfulness exercises; it involves the development of mindfulness skills within the context of parent-child relationships. This involves the everyday practice of mindfulness defined as "the awareness that emerges through paying attention, on purpose, in the present moment, and nonjudgementally to the unfolding of experience moment by moment" (Kabat-Zinn, 2003, p. 145). By applying mindful awareness to parenting interactions, parents can develop an ability to pause their automatic reactions and fundamentally shift their awareness to consider the present moment parenting experience from a relationship-orientated perspective. This can assist parents to consciously observe their own emotional response to their child in the present moment, and exercise self-regulation in order to nonjudgementally reflect on their child's present moment experience. Consequently, this can increase their capacity to attune to, and address, their child's needs, indicating an increased reflective functioning capacity.

This theoretical stance is supported by the findings of a study investigating whether parent mindfulness training would transfer to parent-child interactions (Singh, Lancioni, et al., 2010). Three caregivers of children with multiple disabilities

participated, and the children's non-compliance with their mother's requests were measured as an indirect index of the effects of mindfulness training received by the mothers. Non-compliance was found to decrease during mindfulness training of their mothers and continued to decrease after training completion. The effects of mindfulness practice were reported by all three mothers to gradually seep into their daily life, which included instances of stopping before responding in a habitual manner and instead aligning their response with mindfulness training. Additionally, the mothers reported more mindful and positive interpersonal interactions with their children, spouses and other family members. These behavioural changes were also noticed and verbally reinforced by their children and spouses. Although the mechanisms of change are yet to be investigated, this study provides preliminary evidence of the transfer of mindfulness training effects to parent-child interactions.

Duncan, Coatsworth, and Greenberg (2009) have proposed a model of mindful parenting that encourages greater flexibility and responsiveness in the parent-child relationship. They argue that mindful parenting can disrupt an ingrained destructive cycle of negativity and disengagement which seems to be a common theme amongst parents with BPD trying to raise a child. This model offers five dimensions of mindful parenting that are considered particularly relevant for enhancing the parent-child relationship:

1. Listening with full attention. This allows for an effective use of cues to detect needs or intending meaning which is important for developing an internal representation of the child's perspective.
2. Nonjudgmental acceptance of self and child. This allows for a clear awareness of what is occurring in the present moment and enhances fuller understanding.

3. Emotional awareness of self and child. This increases the capacity to correctly identify emotions and prevents automatic responses.
4. Self-regulation in the parenting relationship. The use of pauses before reacting increases conscious choice of parenting practices, and encourages children to label, express, and discuss their feelings.
5. Compassion for self and child. Compassion may allow for a more forgiving view of one's own parenting abilities and increase a desire to comfort any distress in the child and to meet their needs.

5.5.1 Mindful parenting interventions.

Mindful parenting interventions have been successfully applied to parents of children at varying developmental stages using the previous mindful parenting model. Mindful parent training directed at the parents without their children attending, has been found effective for parents and children with a number of different disorders. Singh and colleagues conducted a 12-session individual mindfulness parenting program for small samples of mothers of children with autism (Singh et al., 2006), developmental disabilities (Singh et al., 2007), and ADHD (Singh, Singh, et al., 2010). The mothers were asked to practice the learnt skills over 52 weeks, and over that period of time there was a reduction in children's problem behaviours (aggression, non-compliance, and self-injury) whilst concurrently the mothers' satisfaction with their parenting skills and mother-child interactions increased. Additionally, in the study with mothers of children with ADHD, the children participated in 12-sessions of individualised mindfulness training during which their medication was tapered and discontinued by physicians (Singh, Singh, et al., 2010). Individual mindful parenting training has also been conducted for parents of young children with behavioural problems over 24-sessions.

Children were reported as having decreased hostile/aggressive behaviour, anxious behaviour, hyperactive/distractible behaviour, and total disturbed behaviour, while parent changes were not assessed (Srivastava, Gupta, Talukdar, Kalra, & Lahan, 2011).

Another mindful parenting program, like Singh, Singh, et al. (2010), provided separate treatment for children and their parents, although in this case both segments of training were run as group programs. Children and adolescents with externalising disorders participated in an eight-session mindfulness course, while their parents (of which 79% had a diagnosis of depression, PTSD, ADHD, or autism spectrum disorder) participated in a parallel mindful parenting course (Bögels, Hoogstad, van Dun, de Schutter, & Restifo, 2008). This group intervention resulted in significant improvements for the children's externalizing and internalizing symptoms, self-control, attention, and social behaviour, while the parents reported improvements in their parenting and the parent-child relationship.

A similar combined Mindfulness/Mindful Parenting group intervention was conducted with children with ADHD and their parents (van der Oord, Bögels, & Peijnenburg, 2012). This resulted in significant ADHD symptom reduction, and decreased parent inattention, impulsivity/hyperactivity, over-reactive parenting, and parental stress. This approach has also been applied successfully with adolescents with ADHD and their parents (Weijer-Bergsma, Formsma, Bruin, & Bögels, 2012), with improvements in adolescents' attention, executive functioning, and externalizing symptoms, and reductions in paternal parenting stress and maternal parental reactivity.

A recent study by Bögels, Hellemans, van Deursen, Römer, and van der Meulen (2014) examined the effects of mindful parenting training carried out within a mental health care context. Parents attended eight weeks of three-hour group sessions plus a follow-up group session eight weeks later. All 86 participants (89% were mothers, 11%

were fathers) reported parent-child relationship problems, with 58% diagnosed with a DSM-IV parent-child relational problem and 31% had their own psychopathology diagnosis. Ninety percent of the children were diagnosed with a DSM-IV childhood disorder. Improvements were found in parental stress and parenting styles, as well as improvement in parent and child internalising and externalising psychopathology.

Other mindfulness-based group intervention programs have sought to prevent the onset of depression and distress in pregnant women and to guard against the onset of postnatal distress. 'Mindful Motherhood' (Vieten & Astin, 2008) was designed specifically for mothers to address the negative impacts of prenatal stress and low mood on mother-infant attachment and child development. The Mindful Motherhood intervention involves eight group sessions of mindfulness education, discussion and experiential exercises, with a focus on pregnancy and early parenting. Pregnant mothers who participated in the pilot program were found to have significantly reduced negative affect and anxiety compared to controls. An Australian study (Dunn, Hanieh, Roberts, & Powrie, 2012) extends these findings with a group treatment program for pregnant women involving eight-sessions of mindfulness-based cognitive therapy (Segal, 2002), modified as appropriate for pregnancy. Nine of the ten participants reported a history of depression and/or anxiety and reported decreased stress, depression and anxiety following the program and 6 weeks post-partum. In addition to increases in mindfulness, self-compassion was found to increase over time.

Overall, the research demonstrates the efficacy of mindful parenting interventions for a range of outcomes that include reduced parental stress, depression and anxiety, increased parental self-compassion, improved parenting, parent-child relationships and child behaviours, and improved externalizing and internalizing psychopathology for parents and their children. Although these mindful parenting

interventions have resulted in positive outcomes for a range of child and parent presentations, they may not be sufficient as a stand-alone intervention for BPD mothers. Compassion and self-compassion are incorporated to address negative evaluations; however, they do not directly address the potential difficulties experienced by parents that are unrelated to their child's behaviour. These interventions focus on the development of mindfulness skills and utilizing these for managing child behaviour and parent-child interactions. This indicates that a mindful parenting approach would be beneficial for mothers with BPD if it was integrated with other treatment approaches that address BPD-specific difficulties.

The association between mindfulness and emotion regulation is an important aspect of mindful parenting interventions, as parental expressions of emotion can impact on children's development of emotional and social competence by influencing their ability to interpret and understand others' emotional reactions and their own emotional experience and expression (Eisenberg, Cumberland, & Spinrad, 1998). As emotion dysregulation is a prominent feature of BPD, a mindful parenting program for mothers with BPD is likely to be beneficial for improving the mothers' emotion regulation abilities, and subsequently have a positive influence on their children's emotional development. The preliminary evidence for mindful parenting is encouraging, and considering the prominence of mindfulness in several BPD treatment approaches, a mindfulness-based parenting intervention for mothers with BPD is a promising treatment consideration that is yet to be explored. Additionally, considering the relationship between impaired attachment organisation and BPD features, along with the efficacy of attachment-based parenting interventions with similar populations, incorporating an attachment component in a parenting program for BPD mothers would be valuable and in line with the Australian clinical practice guidelines for the

management of BPD (National Health and Medical Research Council, 2013) and Stepp at al.'s (2012) recommendations for intervention.

5.6 Summary of Treatment Gaps

In response to the Australian clinical practice guidelines for the management of BPD recommendations for parenting interventions targeted at mothers with BPD, this thesis reviewed the existing literature in the field of BPD, parenting, and treatment interventions. This review identified several evidence-based treatments for BPD and interventions for parenting, however it revealed a gap in the research of specific interventions for mothers with BPD. Three BPD treatments (DBT, MBT, ACT) were reviewed and none of these involve specific parenting interventions. Attachment-based parenting interventions were reviewed, and although these may address some of the parenting difficulties of BPD mothers, none of these were designed to address BPD-specific issues. These interventions tend to focus on the needs of the child and do not directly address the concerns of BPD mothers. As these mothers are likely to have unresolved and traumatic attachment issues, it seems that it would be particularly important to address this in a parenting intervention for mothers with BPD. Mindful parenting interventions were reviewed and although they lack a focus on potential difficulties that BPD mothers can experience, they demonstrate a range of positive outcomes for parent and child, and provide further support for the notion that it may be particularly beneficial to incorporate mindfulness in a parenting intervention for mothers with BPD.

Current research is being conducted for recently developed parenting interventions for mothers with BPD, although findings have not yet been published. It is unclear whether the Australian developed Project Air parenting intervention for PDs

has been developed specifically to address the particular difficulties experienced by BPD mothers. Whilst providing some treatment to reduce parenting difficulties amongst parents with a PD, due to its short nature it is unlikely to be comprehensive enough to address the range of difficulties of BPD mothers. On the other hand, the mentalization-based treatment for parents (MBT-P) module that is currently being piloted in the Netherlands, addresses the parental reflective functioning deficits of parents with BPD in combination with an intensive outpatient program. This program may not be able to sufficiently address the attachment patterns and emotion regulation deficits of mothers with BPD, and the length and intensity of the broader MBT-IOP treatment may limit both accessibility for mothers of young children and attendance consistency. Similarly, while details about the parent-child DBT program currently being developed in the USA have not yet been published, it seems to have the potential to address the treatment gap between BPD treatment and parenting interventions. However, if it is developed as a program of equivalent intensity and length as standard DBT, PC-DBT may potentially have similar accessibility and attendance limitations as the Dutch MBT-P.

Following this review of the literature, there is a clear need for an intervention program designed for mothers with BPD that combines evidence-based BPD treatment approaches and parenting interventions. Considering the attachment experiences of individuals with BPD and the impact this has on their children, an attachment-based parenting intervention approach has been proposed as particularly valuable in the treatment of BPD mothers. Mindfulness is a component of effective BPD treatment and mindfulness-based parenting interventions have demonstrated promising results for both parent and child. As mindfulness is a central component of DBT and ACT, and the

partially overlapping concept of mentalization is a focus of MBT to promote reflective functioning, it appears that a mindfulness-based intervention could address BPD-specific difficulties. This thesis proposes that an integrated treatment approach will successfully address the range of difficulties experienced by BPD mothers including attachment security, maternal sensitivity, reflective functioning, and emotion regulation, as well as result in improved outcomes for both the mothers themselves and their children.

Chapter 6: 'Mindful Parenting Group Intervention for Mothers with Borderline Personality Disorder Traits' (MPG-BPD) Program Development

The current study involves the development and evaluation of a mindfulness-based parenting group program for mothers with BPD traits. The program was developed by Natasha Rogers and Dr Roslyn Galligan from Swinburne University, with aspects of the program more specifically related to BPD group process, mindfulness and emotion regulation developed also in consultation with Dr Katie Wyman, a psychologist from Spectrum the Personality Disorder Service for Victoria. The program content and process was mindfulness-based and informed by existing BPD treatments (including the ACT for BPD group program 'Wise Choices', DBT, and MBT), attachment based interventions ('Watch Wait and Wonder', 'Circle of Security'), and mindful parenting principles. Although other BPD treatments such as schema-focused therapy (ST) have empirical support, the approaches of DBT, MBT and ACT engage in a more present-moment focus, while other approaches such as ST involves a greater amount of self-exploration based on the formation of early maladaptive schemas. The present-moment approach was considered to be more pertinent for changing the parenting experience of mothers with BPD in a short-term group program. The use of BPD treatment components in DBT, MBT and ACT utilised in the MPG-BPD program seemed more applicable for the practice of reflective mindful parenting interactions. Although not explicitly stated, a ST approach was employed in the reflection on participants' experiences in their family of origin and connecting these with their current parenting responses.

Attachment was considered an important component of the current intervention due to the fundamental attachment issues experienced by those with BPD and the

resultant problematic attachment relationships between mothers with BPD and their children, furthered by the positive parent-child outcomes of attachment-based parenting interventions (Cicchetti, et al., 1999; Hoffman, et al., 2006; Suchman, et al., 2010; Van Ijzendoorn, et al., 1995). Based on evidence that poor reflective functioning has a negative impact on the parent-child relationship (Fonagy, Gergely, Jurist, & Target, 2002), and considering Fonagy and Bateman's (2006) proposal that for BPD it is particularly valuable to address reflective functioning deficits within an attachment relationship, this program has a focus on attachment behaviour and reflective functioning within the attachment relationship between mother and child. This involves the provision of potential 'corrective' attachment experiences with the facilitators and other participants within a group setting, attachment psychoeducation informed by COS interventions (Hoffman, et al., 2006), encouraging reflection on the mothers' own childhood attachment relationships, making connections with their current functioning and their own children's needs and attachment cues as informed by WWW interventions (Cohen, et al., 1999; Newman & Stevenson, 2008). These corrective attachment experiences were implemented in accordance with attachment theory and attachment-based parenting interventions. The MPG-BPD program enacted these therapeutic interactions through both the facilitators and the group providing a secure holding environment (Irvin D. Yalom & Molyn Leszcz, 2005), which encouraged the mother's to share and reflect on difficult attachment and parenting experiences both in their own family or origin and in their current interactions with their infants.

Reflective functioning was further advanced through program content that encouraged mothers to develop an understanding of their mental states during mother-child interactions, and how that influenced their responses and actions, as informed by MBT (Bateman & Fonagy, 2004). The parent-child relationship was addressed via

participants own internal and external observations during interactions with their children, as guided by facilitators, in order to enhance the mothers' reflective practice and level of insight. Mentalization was further encouraged through the active reflection on these interactions during sessions, involving reflective questioning by the facilitators and other participants. Facilitators also encouraged participant reflection on their own attachment experiences in childhood, involving their unaddressed childhood needs and consideration of the difficulties that may have been experienced by their caregivers; and making connections between these factors and their current parenting experiences, as well as their own children's current needs and attachment experiences.

Participants' attachment styles were assessed via the quantitative measures of the Experiences in Close Relationship Scale Short Form (Wei, Russell, Mallinckrodt, & Vogel, 2007) and the Relationships Questionnaire (Bartholomew & Horowitz, 1991), as well as by qualitative interview measures to determine whether the MPG-BPD program facilitated change in attachment behaviours and/or styles in the mothers. Changes in reflective functioning and mentalization abilities were also assessed using qualitative interview measures and the quantitative measure of the Parental Reflective Functioning Questionnaire (Luyten et al.).

Mindfulness with a compassionate stance was promoted throughout the program in an attempt to reduce the impact of negative self-evaluations which can result in the emotional reactivity that is a feature of BPD (Gratz, et al., 2010). The Mindful Motherhood intervention of Vieten and Boorstein (2009), and Duncan et al.'s (2009) model of mindful parenting both demonstrate a mindful parenting approach which was adopted due to its efficacy for improving parenting styles, stress, and psychopathology (Bögels, et al., 2014). Mindfulness skills were taught and practiced in a manner consistent with DBT and ACT programs. These mindfulness skills were developed as

strategic approaches for participants to address distress tolerance and emotion regulation issues in the parent-child relationship. Rather than being implemented as separate components of treatment, these DBT-informed skills were incorporated in order to assist participants to generalise their mindfulness skills to parent-child interactions and across a range of difficult life experiences. These skills were assessed using quantitative measures of the Five Facet Mindfulness Questionnaire (Baer, et al., 2006), the Difficulties in Emotion Regulation Scale (Gratz & Roemer, 2004), the Differentiation of Self Inventory (Skowron & Friedlander, 1998), and the Parenting Stress Index (Abidin, 1995), as well as qualitative interview measures.

Components of ACT were applied via the psychoeducation and practice of mindfulness, as well as through the focus on self-compassion, acceptance and parenting values. The participants explored their beliefs regarding the 'ideal' mother, the mother they didn't want to be, and the 'good enough' mother. Through the application of self-compassion and adopting a non-judgemental stance through group processes, the capacity for acceptance of the self and other was enhanced in the mothers. Through this process, participants were encouraged to discover and develop their parenting values and specific parenting goals regarding being a 'good enough' mother and addressing their children's attachment needs. These ACT-informed skills were assessed using qualitative interview measures across the three time points in order to assess for participant change and program efficacy.

As DBT, ACT and mindfulness studies have demonstrated a positive association between mindfulness and emotion awareness, and negative associations with emotion dysregulation and emotional reactivity (Hill & Updegraff, 2012), mindfulness was also employed to address BPD-specific emotion regulation deficits and to further encourage reflective functioning. The development of mindfulness and emotion regulation skills

was a program focus because the Wise Choices ACT intervention for BPD has resulted in BPD symptom improvement (Gratz & Gunderson, 2006; Morton, et al., 2012), and because DBT mindfulness skills training (Linehan, 1993b) has resulted in a significant increase in mindfulness skills over time and correlates with overall BPD symptom improvement (Nicastro, Jermann, Bondolfi, & McQuillan, 2010; Perroud, Nicastro, Jermann, & Huguelet, 2012; Stepp, et al., 2008).

In order to address attachment relationships, reflective functioning, emotion regulation, and other BPD-specific parenting difficulties, the MPG-BPD program integrates several evidence-based components from three major BPD treatments in addition to attachment-based and mindfulness-based parenting interventions. So that the concerns and issues of mothers with BPD can be explicitly discussed and directly addressed, the program is designed to be implemented without the participation of their children. This approach can help the mothers to feel that the program is focused on their needs as well as their child's, and to feel supported to discuss difficulties that are not necessarily about parenting, but may still impact upon the parent-child relationship. Additionally, as highlighted by Zalewski et al.'s (2015) study, this format can allow the mothers to discuss their issues openly without fear of children being exposed to distressing behaviours or listening to conversations that could be inappropriate or distressing for a child. This further operated to address issues of difficult emotional experiences for mothers with BPD, particularly those with histories of trauma, in response to being triggered by their children. These were openly discussed and reflected on within a supportive and accepting group environment. This encouraged participant reflection on their own attachment experiences and promoted the practice of emotion regulation strategies, encompassing mindfulness, in order to increase the capacity to appropriately manage their affective responses in the face of such

challenging experiences. Participant change in parenting stress and emotion regulation was assessed using the quantitative measures of the Difficulties in Emotion Regulation Scale (Gratz & Roemer, 2004), the Differentiation of Self Inventory (Skowron & Friedlander, 1998), and the Parenting Stress Index (Abidin, 1995), and qualitative interview measures.

The potential mechanisms of change in the MPG-BPD program include training participants to use mindfulness-based skills in order to make a conscious choice to regulate their internal and external responses by: a) noticing and become more aware of their internal responses (physical sensations, thoughts, emotions) to their child's behaviours, b) reflecting on why that response is occurring, c) considering alternative options instead of their automatic reaction, d) accepting their child's behaviour and their own internal response rather than reacting automatically, e) implementing a more considered and less reactive response to the situation. As this is a pilot program and there are several overlapping theoretical components involved in this process, a range of quantitative and qualitative measures were applied to assess for participant change and program efficacy, with an aim to assess the specific mechanisms of change in later studies.

The theoretical framework for the MPG-BPD program meets recommendations for BPD parenting interventions made by the Australian clinical practice guidelines (National Health and Medical Research Council, 2013), Stepp et al. (2012), and Newman and Stevenson (2008). The program was designed to be piloted by three female facilitators, with at least one being a mother in order to encourage participants to feel comfortable speaking openly about their experiences of being a mother, and to promote therapeutic alliance and a sufficiently secure 'holding' environment. Having three facilitators also allowed for easier provision of individual support if needed during

sessions. The program as developed is to be implemented over a course of 12 weekly sessions in order to address accessibility and attendance issues for mothers with BPD, as well as to allow enough time to develop mindfulness, emotion regulation and reflective functioning skills, positive therapeutic relationships and connections with other participants.

6.1 Group Treatment for BPD Mothers

Individual psychotherapy tends to be the primary treatment for BPD, however studies have demonstrated a range of clinically meaningful outcomes for individuals with BPD receiving group treatment in addition to treatment as usual (TAU), and these interventions were found to be more effective than TAU alone (Blum et al., 2008; Bos, Van Wel, Appelo, & Verbraak, 2011; Morton, et al., 2012; Verheul, et al., 2003). One study has found the improvements in well-being made by BPD patients participating in a short-term group treatment were at least equivalent to those engaged in longer-term individual therapies (Munroe-Blum & Marziali, 1995). Additionally, the Australian clinical practice guidelines for the management of BPD report that structured psychological BPD treatments have been found effective when delivered as individual or group therapy (National Health and Medical Research Council, 2013, p. 120).

Linehan et al. (2015) recently conducted a randomised clinical trial component analysis of DBT skills training comparing standard DBT (including DBT group skills training and DBT individual therapy), DBT group skills training with manualised case management (without individual therapy), and DBT individual therapy with an activities group (without DBT skills training). The study demonstrated that there were no significant differences between the three versions of DBT for reducing suicidality among high risk participants. Notably, the results indicated that the DBT group skills

training with case management was as effective in reducing non-suicidal self-injury and improving other mental health problems compared to standard DBT, with both found to be more effective than the DBT intervention without group skills training. Although this study did not assess equivalence between standard DBT and DBT group skills training with case management, the findings indicate that BPD treatment in a group format may be as efficacious as standard DBT.

A group treatment program has several advantages over individual treatment including increased cost effectiveness, the provision of treatment to more individuals over a shorter period of time, and the need for fewer professional resources. Additionally, group treatment can provide participants with experiences of connection and support that counter some fundamental BPD relationship issues, and may assist to decrease a sense of isolation and/or defectiveness (Dickhaut & Arntz, 2014; Irvin D. Yalom & Molyn Leszcz, 2005).

6.2 Treatment Approach

The MPG-BPD program was developed specifically for mothers with BPD traits to promote positive changes in parenting. The study aims and hypotheses are discussed in greater detail later in this chapter. The group process is predominantly discussion-based, with psychoeducation approached in a conversational manner in which participants are encouraged to make connections between the program content and their own experiences during childhood and now as a parent.

6.2.1 Modelling reflectiveness.

Reflectiveness is modelled by the facilitators throughout the program, as is recommended for reflective parenting programs in order to develop a reflective stance

in parents (Slade, 2006). By incorporating this approach with mindfulness training and practice, the program promotes the development of the participants' reflective functioning capacity towards themselves and their child. This is intended to increase the awareness of their child's attachment needs whilst also increasing their own ability to respond appropriately, rather than reacting automatically to their own internal responses; particularly if a strong emotion is experienced by their child or elicited in the mother.

6.2.2 The good enough mother.

The concept of the 'good enough mother' is discussed throughout the program, with an explicit focus on how this applies to participants towards the end of the program. The 'good enough mother' concept was introduced by Donald Winnicott (1953) and entails having the ability to understand the child's cues and responding appropriately and consistently. This is based on a foundation of connectedness within the mother-child relationship and motivation to meet the child's health and developmental needs. The 'good enough mother' is about effective parenting rather than perfect parenting. It promotes the idea that imperfect parenting (which involves tolerable failures rather than major traumatising ones) can actually be beneficial for children to learn to manage the challenges that will inevitably arise throughout life and build resilience. This is also beneficial for mothers, as the pressure of striving to be a perfect mother can result in increased feelings of inadequacy, guilt, stress, anxiety and reduced self-efficacy (Flett, Hewitt, Oliver, & Macdonald, 2002; Henderson, Harmon, & Newman, 2015; Warner, 2006).

6.2.3 Self-compassion.

Self-compassion (self-kindness rather than self-judgement) and compassion generally, is also promoted throughout the program and is particularly encouraged prior to the emotion focused sessions. Receiving compassion from self or others assists in the regulation of distress and coping with negative emotions (Cozolino, 2014; Gilbert, 2005, 2009; Mikulincer & Shaver, 2007). As individuals with BPD tend to have reduced emotion regulation and distress tolerance abilities, they are likely to have a limited exposure to being a recipient of compassion and increasing this experience may assist the development of these abilities. Group compassion focused therapy has been found to significantly reduce shame, feelings of self-hatred, social comparison, depression and stress, and increase the ability to self-reassure for individuals diagnosed with a personality disorder (Lucre & Corten, 2013). Self-compassion in parenting has been associated with lower levels of parenting stress (Moreira, Gouveia, Carona, Silva, & Canavarro, 2015) and more functional parent-child relationships with child behaviours less likely to be perceived as difficult and problematic (Neff & Faso, 2015), and is considered to be a key mechanism of the efficacy of mindfulness-based interventions for parents of autistic children (Bögels, Lehtonen, & Restifo, 2010). Additionally, compassion is a component of Duncan et al.'s (2009) model of mindful parenting and Vieten and Astin's (2008) mindful motherhood program. Considering these findings and the relationship with mindfulness, self-compassion is encouraged to reduce mothers' self-criticism and to increase self-care in times of distress in order to assist with emotion management and to increase the mothers' capacity to care for and be compassionate towards their children.

6.2.4 Therapeutic disclosure.

In order to develop rapport and assist in normalising participants' experiences and, in line with Yalom's position that "the therapist who judiciously uses his or her own person in the real time of the group greatly increases the therapeutic power of the group" (I.D. Yalom & M. Leszcz, 2005, p. 218), the program facilitators disclosed some of their own experiences of mindfulness, parenting, self-evaluations and developing self-compassion. This is consistent with the Acceptance and Commitment Therapy stance of therapists and clients being in the same boat as "fellow travellers on the same human journey" (Harris, 2006; 2009, p. 51). It also emphasises the shared value of developing a reflective, compassionate and mindful stance for managing the challenges of life and parenting. This approach was adopted so as to strengthen the therapeutic alliance which is both important, and particularly difficult with BPD clients (Barnicot et al., 2012; Barnicot, Katsakou, Marougka, & Priebe, 2011; Linehan, 1989). Clinical judgement was applied in order to ensure that this was approached professionally and appropriately.

6.3 Program Design

As participants are likely to have experienced attachment trauma, and possibly other traumatic experiences, the group norms (Appendix A) are addressed at the start of session 1 to promote a safe, supportive and accepting group environment. Program sessions were designed to have a fairly uniform structure to provide consistency and predictability for participants. Each session begins and ends with a mindfulness exercise to promote practice, and a review of participants' experiences of mindfulness inside and outside of the session to encourage reflection and highlight positive outcomes. The mindfulness exercise conducted towards the end of a session was

usually repeated at the beginning of the following session to consolidate the skills and allow participants to talk and reflect on how they found this practice, as well as to allow participants who miss a session to have an opportunity to experience the exercise within the group. The early mindfulness exercises were focused on external experiences and then physical sensations in order to facilitate skill development and body awareness prior to focusing on potentially difficult thoughts and emotions. As these internal experiences were likely to be challenging for some participants, particularly due to a tendency for emotional reactivity, two sessions addressed difficult thoughts and self-evaluations, and three sessions addressed emotions and involved emotion identification, the function and purpose of emotions, distress tolerance skills, self-compassion, and acceptance.

The program content can be adjusted based on the abilities of participants in the group. Some participants may have more ease or difficulty with certain concepts (e.g., acceptance) and there may be varying levels of emotion tolerance. Facilitators are required to use their clinical judgment to determine which concepts or exercises are most appropriate to focus on for the participants of a group.

6.4 Overview of Program Content

The following gives a brief overview of the program content and focus of each session. For a more detailed outline of content see Appendix B.

Session 1: Mindfulness and parenting introduction

- Introduction to mindfulness and its use for the individual, parenting and emotion management

Session 2: More mindfulness and parenting

- Mindful parenting and the use of mindfulness to increase awareness and reduce automatic reactions

Session 3: Mindfulness to increase awareness

- Mindfulness to increase awareness of experience including thoughts and judgments about the self
- Mindfulness to increase distress tolerance

Session 4: Mindfulness and acceptance

- Mindfulness and acceptance, highlighting what acceptance is and is not
- Mindful parenting to improve parent-child interactions and relationships

Session 5: Attachment security

- Attachment security with a focus on the needs of children and the role of the parent, incorporating the Circle of Security attachment model
- Introduction to self-compassion

Session 6: Mindfulness for difficult thoughts

- Introduction to the concept of thoughts being just thoughts rather than facts
- Strategies for managing difficult thoughts

Session 7: Self-evaluations and self-compassion

- Self-evaluative thoughts and using mindfulness to increase objectivity
- Self-compassion and self-care

Session 8: Mindfulness of emotions

- Emotion awareness and distress tolerance
- The function and temporary nature of emotions

Session 9: Mindfulness for managing emotions

- Distress tolerance and participants' 'responding to emotions plan'
- Self-compassion for difficult emotions
- Family of origin messages about emotions.

Session 10: Emotion acceptance

- Family of origin emotions
- Mindfulness and acceptance of emotions

Session 11: The good enough mother

- Being a 'good enough mother'
- Perceptions of children compared to the reality of children

Session 12: Mindful parenting

- The use of mindfulness to enact parenting values
- Reflection and review of the program

6.5 Research Approach of the Current Study

6.5.1 Quantitative and qualitative aims and hypotheses.

The main aim of the study was to develop and evaluate a mindfulness-based parenting group program for mothers with BPD traits. The MPG-BPD program was developed to facilitate positive changes in parenting by addressing difficulties in the mother-child relationship while making non-judgmental connections between their own childhood parenting experiences and their current approach to parenting. The program

centred on increasing skills in mindfulness, reflective functioning and emotion regulation so as to help facilitate improvements in general psychological function as indexed by reductions in BPD symptoms and symptoms of depression, anxiety and stress, and to promote positive changes in parenting. In piloting this program pre-, post-program and six-month follow-up quantitative data was collected to evaluate the intervention's effectiveness on specific skills targeted and also on outcomes related to personal well-being and parenting. Like Zalewski et al.'s (2015) study, qualitative data was collected to explore the parenting experiences of mothers with BPD and to aid program development. However, the current study also assessed qualitative data gained from individual interviews across the three time-points in order to examine the change process for participants, explore the participant experience of the program, and to evaluate the program itself. Further qualitative feedback about the program was also obtained in separate focus groups in order to inform the future development and improvement of the MPG-BPD program. The following specific hypotheses and more general research questions were formulated regarding outcomes of participating in the 'Mindful Parenting Group Intervention for Mothers with Borderline Personality Disorder Traits' (MPG-BPD).

6.5.1.1 Quantitative hypotheses.

It was hypothesised that participation in the program would result in:

1. Significantly reduced self-reported levels of BPD symptom severity.
2. Significantly increased mindfulness skills.
3. Significantly increased self-reported levels of parental reflective functioning.
4. Significantly increased self-reported emotion regulation abilities.
5. Significantly reduced self-reported levels of parenting stress.
6. Significantly reduced self-reported levels of depression, anxiety and stress.
7. A greater secure attachment orientation.

6.5.1.2 Qualitative research questions.

Interviews were conducted at pre-program, post-program and six-month follow up and a qualitative research design was employed to allow examination of the following research questions:

1. What changes do participants experience as mothers as a result of participation in the MPG-BPD program?
2. What changes do participants experience in the mother-child relationship as a result of participation in the MPG-BPD program?
3. What changes in reflective functioning do participants experience as a result of participation in the MPG-BPD program?
4. What changes in mood and emotions do participants experience as a result of participation in the MPG-BPD program?
5. What changes in mindfulness do participants experience as a result of participation in the MPG-BPD program?
6. Do participants experience any changes to BPD symptomatology as a result of participation in the MPG-BPD program?

6.5.1.3 Program evaluation questions.

Quantitative and qualitative feedback for program evaluation was obtained via feedback questionnaires, focus groups and interviews to explore the following research questions:

1. What is the subjective participant experience of the program?
2. What do participants report as the most and least effective aspects of the program?
3. What do participants identify as mechanisms of change in the program?
4. What are participants' suggestions for program improvement?

Chapter 7: Method

Two group pilot programs were conducted. Method of recruitment and screening varied somewhat between groups, and therefore are described separately.

7.1 Group One Pilot Program

7.1.1 Recruitment.

The initial pilot program was advertised via phone, email, internet, and mail to the following health professionals and health and support services:

- Public and private hospitals
- Mental health services (adult & child)
- Specialised BPD services
- Private psychologists
- Community health & family services
- Australian Psychological Society
- Maternal & child health services
- Drug & alcohol services
- Sexual assault services
- BPD support groups

The student researcher provided program information to these professionals and services, and flyers were distributed for professionals to refer clients (Appendix C). Flyers advertising the program to clients were distributed to these services and were pinned up on notice boards and uploaded online (Appendix D).

7.1.2 Inclusion criteria.

The following inclusion criteria were required for the 'Mindful Parenting Group Intervention for Mothers with Borderline Personality Disorder Traits' pilot: a) Over 18 years of age; b) Mother of a child aged between 1 and 10 years; c) Met Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000) criteria for Borderline Personality Disorder, or assessed as reaching subthreshold levels of the diagnosis (i.e., met diagnostic criteria for three or four symptoms); d) Not identified as currently being at high risk of self-harm or suicide, or in crisis (experiencing overwhelming emotional distress and psychosocial dysfunction).

7.1.3 Screening.

Fifteen potential participants were initially screened for eligibility over the phone by the student researcher and clinical psychologist. Eight were referred by health professionals (case manager, psychologist, or support worker), and seven self-referred after seeing the advertisement flyer at a health or support service. Ten of these potential participants were considered eligible for the assessment interview. Interview times were arranged, with five attending the initial assessment interview with the provisional psychologist and five not attending despite rescheduling and follow-up phone calls.

Prior to attending the assessment interview, potential participants were sent a demographic information form (Appendix E) and an information statement and consent form (Appendix F). The information statement gave an overview of the program, the potential benefits of the program, and of the research component. The information statement also informed potential participants that their participation was voluntary, their right to withdraw at any time, the potential risks, and that their privacy and confidentiality would be protected. They were encouraged to raise any concerns or

queries prior to or during the interview. The consent form outlining the entailments of participation was completed by potential participants prior to the interview being conducted. A consent form for information about therapeutic treatment and/or support work to be released by their health professional (Appendix G) was also provided at the interview for participants to complete if they chose.

Participants were asked about any prior psychiatric diagnoses, and were diagnostically assessed for BPD, mood disorders, and anxiety disorders by the provisional psychologist in the initial pre-program interview using the Structured Clinical Interview for DSM-IV (SCID-II). BPD diagnosis and symptom severity were also evaluated in the initial pre-program interview using a modified version of the Borderline Personality Disorder scale of the Personality Diagnostic Questionnaire-4th Edition (PDQ-4+) and the Borderline Evaluation of Severity over Time (BEST) scale.

One potential participant was not considered eligible due to an inability to answer the interview questions because of an intellectual disability. After the program was described to her, this mother decided the program was not right for her, as she was not interested in talking about concepts such as what it means to her to be a mother, or mindfulness. Rather she wanted a program that provided practical training in parenting.

7.1.4 Group attendance.

Four participants enrolled in Group One of the pilot program. This included two mothers with BPD and two mothers with BPD traits. One participant with BPD attended two sessions and could not continue due to being offered a place in a residential drug rehabilitation program. One participant with BPD traits attended all 12 sessions, one participant with BPD attended 11 of the 12 sessions, missing one session due to being ill; and one participant with BPD traits attended seven of the 12 sessions,

missing two sessions due to her child being unwell, and missing three sessions because she was overseeing her family home being built and had meetings that interfered with these sessions. Data for these three participants who completed the post-program measures were included in the evaluation.

7.2 Group Two Pilot Program

7.2.1 Recruitment.

Due to the difficulties recruiting from this population and low participant numbers in the pilot program, a second group program was conducted in partnership with Banyule Community Health, a state government funded community health service that provides a range of services in primary health and welfare to the community. Participants were recruited through the service's health professionals and the group was conducted on-site at the Community Health Service. The inclusion criteria were unchanged.

7.2.2 Screening.

Nine potential participants were referred by a health professional (case manager, general practitioner, psychologist, counsellor, mental health nurse, support worker) and were screened for eligibility via the health professional or directly over the phone. Seven of these potential participants were considered eligible for the assessment interview. Interview times were arranged, with all seven attending the initial assessment interview with the provisional psychologist.

The demographic information form, information statement and consent procedure remained the same, with the information statement updated with the new

program dates and venue information (Appendix H). The assessment procedures were unchanged.

One potential participant was 16 years old and was interviewed at the request of her social worker, who reported that this young mother had participated well in other groups with older mothers. She was not considered eligible because she was much younger and relatively immature compared to other participants. One potential participant was eligible for the program, however she was unable to attend due to her mother becoming seriously unwell and having to care for her indefinitely.

7.2.3 Group attendance.

Five participants enrolled in Group Two of the pilot program. This included three mothers with BPD and two mothers with BPD traits. One participant with BPD attended four sessions and withdrew from participation due to an involuntary admission to a psychiatric inpatient unit following a relapse of Bipolar Disorder. One participant with BPD traits attended all 12 sessions and one participant with BPD traits attended 11 of the 12 sessions, missing one session due to her child being unwell. One participant with BPD attended 8 of the 12 sessions, missing four sessions due to being ill, wisdom tooth removal, her child being unwell, being unable to arrange child care, and attending an interview for a course. One participant with BPD was only able to attend 5 of the 12 sessions due to her difficulties with mood and coping abilities, being unable to arrange child care, and unexpected circumstances occurring that interfered with these sessions. Except for the first participant, who withdrew from the program, all participants (n = 4) were included in the evaluation.

7.3 Participants

7.3.1 Demographics.

The three Group One participants ranged in age from 40 years to 49 years (M = 45.00; SD = 4.58). Two participants had two children and one participant had three children. The children's ages ranged from 6 years to 14 years (M = 9.14; SD = 2.73), with all participants having at least one child aged 10 years or younger. All three participants were married and all the children lived with both parents. All three participants were unemployed and financially supported by their husbands' wage.

The four Group Two participants ranged in age from 27 years to 44 years (M = 38.25; SD = 7.54). All participants had one child under 10 years of age, however one participant also had an adult child aged 24 years who lived independently and had their own child. The children's ages ranged from 1 to 7 years (M = 5.00; SD = 2.71), with 3 children $\leq$ 6 years old and one child aged 1 year. Three participants were single and not cohabiting, and one participant was married. All the children lived with their mother full-time. All participants were unemployed and financially supported by government payments.

7.3.2 Participant profiles.

To provide contextual information, brief profiles of each of the seven participants who attended the program and completed the post-program assessments are provided. Note pseudonyms are used in all cases.

Kate was 40 years old and married with two sons aged 8 and 6 years. She was unemployed, had post-graduate qualifications in information management and librarianship, and had most recently worked as a librarian in 2013. Her husband worked full-time and their family lived in a western suburb of Melbourne, Australia. Kate had

been previously diagnosed with Bipolar Disorder, Dysthymic Disorder, and BPD over a period of 15 years from her early 20s. She had received past mental health support from psychologists and had been an inpatient in public psychiatric units several times. She was receiving mental health support via case management at the time of the group. She was offered and accepted individual psychological support from the clinical psychologist during the time of the group program, due to suicidality being triggered by aspects of the program. On assessment, Kate was diagnosed with Bipolar II Disorder, and BPD with all nine criteria being endorsed.

Fiona was 49 years old and married with three daughters aged 14, 11 and 7 years. She was unemployed, had qualifications in management and science marketing management, and had most recently worked in administration in 2006. Her husband worked full-time and their family lived in a southern suburb of Melbourne, Australia. Fiona had no prior formal diagnoses, however reported experiencing periods of low mood. In the past she would have met criteria for Posttraumatic Stress Disorder as a result of witnessing her sister experiencing psychotic episodes without receiving an explanation of this when she was a young child, and on one occasion witnessing her sister holding a sword to the neck of her other sister. Fiona had received past mental health support within the public health system from a psychologist and a psychiatrist. At the time of the group, she was receiving mental health support from a public psychologist. On assessment, Fiona endorsed 4 of 9 BPD criteria, meeting subthreshold levels of BPD.

Aisyah was 46 years old and married with two daughters aged 10 and 8 years. She was unemployed, had qualifications in architectural technology and had most recently worked in this vocation in 2007. Her husband worked full-time and their family lived in an eastern suburb of Melbourne, Australia. Aisyah was diagnosed with

BPD in 2006. She reported several traumatic experiences throughout her life which included witnessing a person being shot at her workplace, witnessing others being badly injured and die, and being in a serious car accident caused by a drunk driver. Aisyah was not receiving mental health support at the time of the group, however in the past had been admitted to a private psychiatric inpatient unit, received mental health support from a private psychiatrist, and attended a Dialectical Behaviour Therapy course. On assessment, Aisyah was diagnosed with Panic Disorder with Agoraphobia and Specific Phobia (animal type). She endorsed 4 of 9 BPD criteria, meeting subthreshold levels of BPD.

Jessica was 41 years old and married with one son aged 1 year. She was unemployed, had degrees in drama and English, and had most recently worked in retail in 2012. Her husband worked casually and her family lived with a housemate in a northern suburb of Melbourne, Australia. Jessica had previously been diagnosed with Depression at age 16, a psychotic episode in the context of depression when she was 20, and Posttraumatic Stress Disorder following sexual assaults at ages 18 and 26. She reported a history of BPD symptomatology and a likely past substance use disorder. She had received past mental health support for depression from a private psychiatrist, had been an inpatient in a private mental health service several times, and had been admitted to psychiatric units in public hospitals twice in 2013. At the time of the group, Jessica was receiving mental health support within the public health system from a psychologist, mental health nurse, general practitioner, and psychiatrist. On assessment, Jessica was diagnosed with Major Depressive Disorder, recurrent, in full remission with antidepressant medication. She no longer met full criteria for Posttraumatic Stress Disorder. She endorsed 3 of 9 BPD criteria, meeting subthreshold levels of BPD.

Alena was 43 years old and single with one daughter aged 6 years. She was unemployed, had a qualification in business administration, and had most recently worked in Duty Free in 2007. She and her daughter lived with her parents in a northern suburb of Melbourne, Australia. Alena had no prior formal diagnoses, however reported experiencing symptoms of depression and anxiety, as well as a lengthy history of problematic gambling until a few months prior to the program. She had received mental health support from a psychologist in the past. At the time of the group Alena was receiving mental health support within the public health system from a psychologist and psychiatrist. On assessment, Alena endorsed 3 of 9 BPD criteria, meeting subthreshold levels of BPD.

Kylie was 27 years old and single, with one son aged 6 years. She was unemployed, had completed her VCE, and had most recently worked in retail in 2010. She and her son lived together in a northern suburb of Melbourne, Australia. Kylie had previously been diagnosed with Depression, Anxiety and Bipolar Disorder when she was 20 years old and had been diagnosed with Posttraumatic Stress Disorder when she was 26. She reported a history of bulimia and BPD symptomatology. She had received mental health support from a psychologist in the past. At the time of the group, Kylie was receiving mental health support from a psychologist and general practitioner. On assessment, Kylie was diagnosed with Bipolar II Disorder, Posttraumatic Stress Disorder, chronic in duration, as a result of a threatening and violent past relationship, and BPD with five criteria being endorsed.

Daria was 42 years old, single, with two living children. She had a 24-year-old daughter who lived independently and had her own child. She had a daughter who died from sudden infant death syndrome at 3 months of age in 2006. She had a son aged 7 years, who she lived with in a northern suburb of Melbourne, Australia. She was

unemployed, had completed a qualification in information technology, and had previously worked in warehousing and driving. Daria had previously been diagnosed with Agoraphobia and Posttraumatic Stress Disorder. She reported past traumas including being sexually assaulted as a young adult and giving her baby CPR prior to her death. At the time of the group, Daria was receiving mental health support from a family service and a drug dependency unit. On assessment, Daria was diagnosed with Substance Dependence, Substance Induced Mood Disorder, Substance Induced Anxiety Disorder, Posttraumatic Stress Disorder, and BPD with seven criteria being endorsed.

7.4 Study Design

Two pilot groups of the 'Mindful Parenting Group Intervention for Mothers with Borderline Personality Disorder Traits' (MPG-BPD) were conducted using the program manual, first at a University Psychology Clinic and then at a Community Health Service. Qualitative and quantitative data were collected in the three weeks prior to the program commencing, at post-program within three weeks of completion, and at six-month follow-up. Following the pre-program screening process, a face-to-face semi-structured interview was conducted with eligible participants, who were then given quantitative questionnaires to complete and return to the facilitators prior to, or at, the first session. On program completion, participants were given the quantitative questionnaires to complete and return to the facilitator at their scheduled post-program interview, and focus groups were conducted. Quantitative questionnaires mailed to participants, were returned to the facilitator at the individually scheduled six-month follow-up interview.

7.4.1 Program facilitators.

Each pilot program was conducted by three female facilitators, the clinical psychologist who was the research supervisor and two postgraduate psychology students with at least provisional registration. The registered clinical psychologist was aged in her 60s, had children and grandchildren, and specialised in child and family therapy. She had experience practicing mindfulness, working with clients with BPD and therapeutically assisting them with parenting on an individual basis, and also facilitating therapeutic mindfulness parenting groups for mothers suffering postnatal depression. The provisional psychologist who had designed the program for research in conjunction with the research supervisor, was undertaking a Doctorate in Clinical Psychology. She was in her early 30s and did not have children. She had experience in the practice of mindfulness, facilitating therapeutic groups, providing individual therapy and support work to clients with BPD, and working within primary mental health, continuing care and inpatient teams. In the first pilot program the third facilitator was a provisional psychologist undertaking a PhD/Masters in Clinical Psychology. She was in her early 40s and had three children aged 10, 8 and 7. She had previous experience working as a child and adolescent counsellor, consulting with perinatal and infant mental health services, running a divorce recovery program for children, and had trained as a parent effectiveness training facilitator. In the second pilot program the third facilitator was a registered psychologist undertaking a Masters in Clinical Psychology. She was in her late 30s and had two children aged 9 and 6. She had previous experience working therapeutically with clients with BPD, implementing Dialectical Behaviour Therapy in individual and group settings, working therapeutically with children and adolescents, and working in crisis assessment, continuing care and inpatient teams. Each pilot group consisted of three female facilitators with differing

parenting experiences and consisted of one facilitator who was a mother and grandmother, one facilitator who was a mother, and one facilitator who was not a mother.

7.4.2 Program sessions.

The program was conducted over 12 sessions, with each session running for 2 hours with a 10-minute break. The sessions were run weekly, except for 1-2 week breaks during school holidays unless all participants agreed they could attend during those weeks. Each session followed a fairly uniform structure:

- Mindfulness exercise (5 – 20 minutes)
- Review of the mindfulness practice
- Reflect on the previous session and discussion of any homework
- Introduction and discussion of session topic
- Coffee/tea break with food
- Introduction and discussion of the next session topic
- Mindfulness exercise (5 - 20 minutes)
- Brief reflection on the mindfulness exercise
- Home practice

A detailed description of the program sessions is contained in Appendix B. The facilitators made minor adjustments to the delivered program due to participant abilities, needs, and distress levels. For example, participants with greater difficulties tolerating emotions were encouraged to focus on mild emotions for the emotion focused mindfulness exercises and were provided with additional self-compassion exercises. However, efforts were made to maintain the integrity of the program and complete all components of each session.

Participants used the sessions to acquire and practice mindfulness skills, discuss their experiences of mindfulness, discuss what they have noticed about how session topics relate to their own lives, discuss issues of concern, feedback achievements to the group, and provide support to each other.

7.5 Measures

7.5.1 Demographic variables.

A demographic information form was developed for this study (Appendix E). Background demographic data included date of birth, relationship status, children's ages, living situation, education, employment status, psychological and psychiatric treatment history, and mental health diagnoses.

7.5.2 Diagnostic assessment measure.

A diagnostic assessment using a shortened version of the Structured Clinical Interview for DSM-IV (SCID-II; First, Spitzer, Gibbon, & Williams, 1997; First, Spitzer, Williams, & Gibbon, 1997) was conducted in the pre-program interview to screen for BPD, mood disorders and anxiety disorders. The SCID is a semi-structured interview to assist mental health professionals with making DSM-IV diagnoses for Axis I and Axis II disorders. The Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) has been published since this study was conducted, with some changes made to the criteria for mood and anxiety disorders. The diagnostic criteria for BPD have remained the same, although the DSM-5 includes an alternative model for personality disorders based on "impairments in personality functioning and pathological personality traits" (American Psychiatric Association, 2013, p. 761).

The SCID is the most comprehensive and frequently used semi-structured assessment instrument for clinical disorders (Groth-Marnat, 2009). It is clinician-administered, with questions designed to elicit information relevant to diagnostic criteria and includes prompts requesting specific examples from subjects, allowing the interviewer to determine whether each individual DSM-IV criterion is met. The SCID-I covers most Axis I disorders, including mood disorders and anxiety disorders. The SCID-II covers the Axis II personality disorders including BPD. The SCID-II brief overview focuses on questions about general personality characteristics. This overview was used at the beginning of the pre-program screening interview to build rapport and ease participants into the interview process. The BPD module of the SCID-II was used to assess whether potential participants met criteria for a diagnosis of BPD, or whether enough of the BPD criteria were met to reach subthreshold levels of BPD. For the purposes of this study, participants were considered to meet subthreshold levels of BPD if they endorsed 3 or 4 of the 9 BPD criteria.

Reliability studies have demonstrated variable results, with overall good interrater reliability and moderate test-retest reliability (First & Gibbon, 2004). A recent study of interrater reliability of the SCID among a mixed sample of inpatients and outpatients, found fair to excellent interrater agreement for 12 SCID I diagnoses (κ = 0.61 to 0.83; Lobbestael, Leurgans, & Arntz, 2011). Excellent interrater agreement was demonstrated for the BPD diagnosis (κ = 0.91). Since SCID validity studies have assumed DSM-IV diagnoses to be the benchmark for making comparisons of diagnostic accuracy, 'procedural validity' has often been assumed (Rogers, 2001). Although it is flawed, 'best estimate diagnosis' may be the most accepted standard that can be used in psychiatric diagnostic studies (First & Gibbon, 2004). Using this approach, two studies have demonstrated the SCID to have superior validity over standard clinical interviews

(Basco et al., 2000; Kranzler, Kadden, Babor, Tennen, & Rounsaville, 1996). Skodol, Rosnick, Kellman, Oldham, & Hyler (1988) compared results of a personality assessment using the SCID-II for the DSM-III-R with a 'longitudinal expert evaluation using all data' (LEAD) standard, and found the diagnostic power of SCID (ratio of true test results to total number of tests administered) to be 0.85 for BPD.

7.5.3 Quantitative measures.

The following quantitative measures were used to track change from pre- to post-program to six-month follow-up.

7.5.3.1 *The Personality Diagnostic Questionnaire-4th Edition (PDQ-4).*

The PDQ-4 (PDQ-4; Hyler, 1994) is a self-administered 99-item, true/false questionnaire designed to assess the DSM-IV personality disorders and is most frequently used in clinical practice. Each item corresponds to a DSM-IV personality disorder diagnostic criterion (Bagby & Farvolden, 2004). The most recent version is the PDQ-4+, with the plus referring to two additional personality disorders (passive-aggressive and depressive) proposed in DSM-IV (Bagby & Farvolden, 2004). In this study, the Borderline Personality Disorder scale was used to assess BPD diagnosis and symptom severity. The BPD scale was modified from true/false responses to use of a 5-point Likert-type scale ranging from 0 (never) to 4 (nearly always) (Appendix I). The scale was modified in order to evaluate the severity of the BPD criteria reflected in the nine questionnaire items (Lewis, Griffin, Winstead, Morrow, & Schubert, 2003). Higher scores represent greater endorsement of BPD symptoms.

There have been relatively few published studies evaluating the psychometric properties of the PDQ-4 to date. The PDQ-R, a previous version of the PDQ-4, has

demonstrated good convergent validity with other personality disorder measures (Hyler, Skodol, Kellman, Oldham, & Rosnick, 1990) and adequate test-retest reliability (Hurt, Hyler, Frances, Clarkin, & Brent, 1984). Two studies (Fossati et al., 1998; Wilberg, Dammen, & Friis, 2000) found the PDQ-4+ to have acceptable internal consistency for the original true/false BPD scale (α = .70; .67 respectively). Bouvard, Vuachet, and Marchand (2011) found the agreement between the SCID II and PDQ-4+ for BPD to be moderate (κ = 0.51). A similarly modified version of the PDQ-4+ BPD scale was found to have good reliability with an alpha coefficient of .79 (Lewis, et al., 2003).

7.5.3.2 *The Borderline Evaluation of Severity over Time (BEST).*

BPD-specific symptom severity was also evaluated with the BEST (Pfohl et al., 2009) (Appendix J), a 15-item, 5-point Likert self-report scale that assesses the degree of impairment or interference from each of the nine BPD criteria over the past month. The BEST assesses thoughts, feelings and behaviours associated with BPD. Subscale A (Thoughts and Feelings) assesses mood reactivity, identity disturbance, unstable relationships, anger, abandonment fears, paranoia, emptiness, and suicidal thinking; Subscale B (Behaviours – Negative) rates negative actions such as self-injury, impulsive behaviours, and anger outbursts; Subscale C (Behaviours – Positive) rates positive actions such as following thought with therapy plans. Higher scores on subscales A and B indicate greater BPD symptom severity, and higher score on subscale C indicate greater acquisition of positive behaviours. Total BEST scale scores are calculated by adding the totals of subscales A and B, subtracting the total of subscale C and adding a correction factor of 15. The total BEST score can range from 12 (least severe) to 72 (most severe). The BEST has been found to be sensitive to change, have

good test-retest reliability and excellent internal consistency (Blum, Pfohl, John, Monahan, & Black, 2002; Pfohl, et al., 2009).

The modified BPD scale of the PDQ-4+ and the BEST were used for screening purposes and diagnostic confirmation at the initial pre-program interview, and to measure BPD symptom severity across the three time points (pre-, post-program, six-month follow-up). The PDQ-4+ assesses DSM-IV criteria, while the BEST differs from other measures of BPD by focusing on how symptomatology changes over time, rather than diagnosis. Subscales A and B are based on DSM-IV criteria and differentiating thoughts and feelings from negative behaviours, and subscale C assesses the acquisition of positive behaviours, as this is likely to influence subscales A and B.

7.5.3.3 *The Five Facet Mindfulness Questionnaire (FFMQ).*

Mindfulness skills were measured using the FFMQ (Baer, et al., 2006) (Appendix K), a self-report measure consisting of 39 items, rated on a 5-point Likert scale, assessing five facets of the tendency to be mindful in daily life: observing, describing, acting with awareness, non-judging of inner experience, and non-reactivity to inner experience. Higher scores on FFMQ subscales indicate greater levels of those facets of mindfulness, and higher scores on the total FFMQ score indicate greater levels of mindfulness in daily life. Total FFMQ scores can range from 30 to 195. The FFMQ has demonstrated good internal consistency and significant relationships in the predicted directions with a variety of constructs related to mindfulness (Baer, et al., 2006).

7.5.3.4 *The Parental Reflective Functioning Questionnaire (PRFQ).*

The PRFQ (Luyten, et al.) (Appendix L) is a brief 18-item, multidimensional assessment based upon the Parent Development Interview that measures parental reflective functioning in the specific context of the parent-child relationship. Each item is rated on a 7-point Likert scale. The PRFQ assesses three dimensions of reflective functioning: (a) interest and curiosity in mental states (IC; awareness that mental states underlie behaviour and curiosity about these mental states), (b) certainty about mental states (CMS; the ability to recognise the opacity of mental states), (c) pre-mentalizing (PM; nonmentalizing modes of thinking characteristic of parents with severe impairments in parental reflective functioning). Higher scores on the IC subscale indicate a greater level of reflective functioning, while lower scores on the CMS and PM subscales indicate a greater level of reflective functioning. For the purposes of this study, the CMS and PM scoring were reversed so that increased scores represented increased reflective functioning in all three dimensions. To facilitate ease of interpretation in this study, the Pre-Mentalizing and Certainty about Mental States subscales were renamed Mentalizing and Lack of Certainty about Mental States respectively. The three-factor structure has been supported by exploratory and confirmatory factor analysis in two different samples and holds for both mothers and fathers. The PRFQ has good internal consistency with $\alpha = .75$ for IC, $\alpha = .82$ for CMS, and $\alpha = .70$ for PM (Luyten, Mayes, Njissens, & Fonagy, 2014). The PRFQ was primarily designed for parents of children aged 0-5 years, when children are in early stages of development, mental states need to be inferred and the ability to be responsive to mainly non-verbal cues may be an important determinant of the subsequent socioemotional development of the child. The process of mentalization with children over 5 years might involve some different processes and capacities; however, this has

not yet been assessed using the PRFQ. Due to the lack of quantitative measures addressing reflective functioning, this study has used the PRFQ to assess parental reflective functioning in mothers of children aged up to 10 years.

7.5.3.5 *Difficulties in Emotion Regulation Scale (DERS).*

The DERS (Gratz & Roemer, 2004) (Appendix M) is a 36-item, 5-point Likert scale measure that assesses individuals' typical levels of emotion dysregulation across six separate dimensions of emotion regulation: non-acceptance of negative emotions, inability to engage in goal-directed behaviours when experiencing negative emotions, difficulties controlling impulsive behaviours when experiencing negative emotions, limited access to emotion regulation strategies perceived as effective, lack of emotional awareness, and lack of emotional clarity. Higher score in each subscale indicate greater difficulties in emotion regulation. The DERS has been found to have high internal consistency ($\alpha = .93$), good test-retest reliability, and adequate construct and predictive validity (Gratz & Roemer, 2004).

7.5.3.6 *Differentiation of Self Inventory (DSI).*

Two subscales of the DSI (Skowron & Friedlander, 1998) (Appendix N) were also used to measure emotion regulation on a 6-point Likert scale: Emotional Reactivity (11-items) and Emotional Cutoff (12-items). The items on these subscales reflect difficulties in handling affect, with Emotional Reactivity reflecting the degree of emotional response (hypersensitivity, emotional flooding, or emotional lability) to environmental stimuli, and Emotional Cutoff reflecting the reaction of emotional distance in response to a perceived threat of intimacy and feelings of vulnerability in relations with others. Higher scores on the DSI subscales indicate greater

differentiation of self (i.e., a lower level of emotional reactivity and emotional cutoff). For the purposes of this study, the Emotional Reactivity and Emotional Cutoff scoring was reversed so that increased scores represented increased emotional reactivity and cutoff. The DSI subscales have been found to have good construct validity and internal consistency reliabilities with $\alpha = .84$ for Emotional Reactivity, and $\alpha = .82$ for Emotional Cutoff (Skowron & Friedlander, 1998).

7.5.3.7 *The Parenting Stress Index (PSI).*

The PSI (Abidin, 1995) (Appendix O) is a 120-item self-report scale that identifies parent-child systems that are under stress, and the Parent Domain identifies those at risk for the development of dysfunctional parenting behaviours. High scores on the Parent Domain indicate individuals who feel overwhelmed and inadequate in the task of parenting. The PSI has high internal consistency (Parent Domain $\alpha = .70$ to .84), its stability is supported by test-retest reliability coefficients ranging from .69 to .71 for the Parent Domain, and its construct and predictive validity has been demonstrated across numerous studies (Abidin, 1995). A short form of the PSI was developed for this study to assess parenting self-efficacy and other features of interest. The subscales that will be included are from the Parent Domain are: Competence (13-items), Isolation (6-items), Role Restriction (7-items), and Attachment (7-items). The Competence subscale assesses the parent's sense of competence in their role as parent. The Isolation subscale assesses the parent's sense of social isolation and the availability of parent role social support. The Role Restriction subscale examines the perceived impact of parenthood on personal freedom and other life roles. The Attachment subscale assesses the parent's intrinsic investment in the role of parent. To facilitate ease of interpretation in this

study, the Competence and Attachment subscales were renamed Lack of Competence and Attachment Dysfunction respectively.

7.5.3.8 *The Depression Anxiety Stress Scale (DASS).*

The DASS (Lovibond & Lovibond, 1995) (Appendix P) is a 42-item questionnaire rated on a 4-point Likert scale that assesses three dimensions of negative emotion states, specifically depression, anxiety, and stress. The Depression scale measures symptoms typically associated with dysphoric mood. The Anxiety scale assesses symptoms of physical arousal, panic attacks and fear. The Stress scale evaluates symptoms such as tension irritability and a tendency to overreact to stressful events. Within clinical samples, the DASS has been found to have good internal consistency and test-retest reliability (Brown, Chorpita, Korotitsch, & Barlow, 1997), as well as adequate construct and discriminant validity (Antony, Bieling, Cox, Enns, & Swinson, 1998; Brown, et al., 1997; Lovibond & Lovibond, 1995). This study used a 21-item version of the DASS (found to be comparable to the 42-item version; Antony, et al., 1998). The DASS-21 has high internal consistency with $\alpha = .94$ for Depression, $\alpha = .87$ for Anxiety, and $\alpha = .91$ for Stress (Antony, et al., 1998). The Australian subscale norms for Depression ($M = 6.34$, $SD = 6.97$), Anxiety ($M = 4.70$, $SD = 4.91$), and Stress ($M = 10.11$, $SD = 7.91$) are used for rating respondents' levels of severity (Lovibond & Lovibond, 2004).

7.5.3.9 *Experiences in Close Relationship Scale Short Form (ECR-S).*

The ECR-S (Wei, et al., 2007) (Appendix Q) is a 12-item, 7-point Likert scale designed to assess a general pattern of adult attachment based on the dimensions of Anxiety and Avoidance. High scores on either or both dimensions are considered to

indicate an insecure attachment orientation, whereas low scores indicate a secure attachment orientation. The ECR-S has been found to have acceptable internal consistency (with coefficient alphas ranging from .77 to .86 for the Anxiety subscale, and ranging from .78 to .88 for the Avoidance subscale), test-retest reliability, and construct validity (Wei, et al., 2007).

7.5.3.10 *The Relationships Questionnaire (RQ).*

The RQ (Bartholomew & Horowitz, 1991) (Appendix R) assesses adult attachment styles by presenting paragraph descriptions of each of four attachment prototypes (secure, preoccupied, dismissing, and fearful) and asks respondents to choose the description that best characterises how they are in close relationships. Respondents are also asked to rate each description on a 7-point Likert scale ranging from 1 (not at all like me) to 7 (very much like me) according to the extent each description applies to them. The RQ classifications have been found to have acceptable reliability estimates (Crowell, Fraley, & Shaver, 2008).

7.5.4 Qualitative measures.

7.5.4.1 Pre-program semi-structured interview.

A pre-program face-to-face interview (Appendix S) was conducted with eligible participants following the pre-program screening process. The interview schedule consisted of 19 open-ended questions investigating the following: (a) the participants' experience of being a mother, (b) how they perceive their parents' parenting styles, and how this compares to their own parenting style, (c) how they perceive others (child and partner) to view of them as a mother, and (d) their perception of the ideal mother, good

enough mother, and mother they don't want to be; and how they view themselves in relation to these concepts.

7.5.4.2 Post-program semi-structured interview.

A post-program face-to-face interview (Appendix T) was conducted with eligible participants following the program completion and at a six-month follow-up. The interview schedule consisted of 24 open-ended questions investigating the following: (a) the participants' current experience of being a mother, (b) how they perceive themselves in relation to the good enough mother, and (c) changes participants' have noticed since completing the group or since the last post-program interview; with a focus on changes in their experience of being a mother, in their relationships, in self-evaluations, in mindfulness, in mood, and in the management of difficult thoughts and emotions. An additional question exploring obstacles to attendance was included following Group Two, because some participants' attendance was not consistent during the program.

7.5.4.3 ***Post-session feedback questionnaire.***

A short questionnaire was designed to record participants' feedback immediately after each session (Appendix U). The questionnaire asked them to rate the following: (a) the degree to which they found the activities and discussions to be useful or relevant, (b) the degree to which they feel mindfulness will be of use to them as a mother and in their life generally, and (c) the degree to which they liked the mindfulness practice in the session. Participants were asked to identify the most enjoyable part of the session and what could be improved in the session. Participants were also asked how often they practised mindfulness in the past week.

7.5.4.4 *Post-program feedback questionnaire.*

A short questionnaire was designed to record participants' feedback following completion of the group program (Appendix V). The questionnaire asked them to rate the following: (a) the degree to which they found the activities and discussions to be helpful and (b) the degree to which they found mindfulness to be helpful for them as a mother and in their life generally. Participants were asked to identify which sessions were most helpful, what was most helpful about those sessions, what was most enjoyable about the group, what could be improved, and any changes noticed since the group began. Participants were also asked how often they practised mindfulness before attending the group and after completing the group.

7.5.4.5 *Focus group questions.*

To inform program evaluation, a focus group was conducted within the two weeks following the conclusion of each group program to gain qualitative information from the participants about the program. Participants were invited to attend the focus group and were asked 21 open-ended questions (Appendix W) about their appraisal of the program, the impact of the program, the program content and process, and their suggestions for improvement.

7.6 Procedure

Ethics approval (Appendix X) was obtained by the Swinburne University Human Research Ethics Committee prior to advertising the program. Recruitment and eligibility screening was conducted by the facilitators as described earlier in this chapter. Pre-program qualitative interviews each of approximately two to three hours duration, were conducted and recorded by the facilitators with eligible participants

following the screening procedure. Participants were given the quantitative questionnaires to complete and return to the facilitators prior to/at the first session. At the end of each session, feedback questionnaires were completed by participants. On program completion, individual interview times and a focus group time were scheduled during the following three weeks. Participants were given the post-program feedback questionnaire and the quantitative questionnaires to complete and return to the facilitator conducting the interviews. The qualitative post-program interviews of approximately two to three hours each were conducted with data collected and recorded. The qualitative program evaluation data was collected and recorded during the focus groups that were approximately two hours in duration. Approximately five months after program completion, participants were contacted by a facilitator via telephone to schedule six-month follow-up interviews. The quantitative questionnaires were posted to participants to complete and return when attending the qualitative interview. Text messages were sent to confirm interviews and to remind participants to bring the questionnaires to the interview. If a participant forgot to complete or bring the questionnaires to the interview, the facilitator requested the questionnaires be completed at that time, or if this was not possible for the participant to complete and return the questionnaires within a week. The six-month follow-up interview data was collected and recorded by the facilitator at the individual interviews that were approximately one to two hours duration. Details about the data analysis procedures are described in the following results chapters.

Chapter 8: Results

The rationale and description of the analyses performed in the study are presented in four sections. First, the results of the statistical analyses performed on the group quantitative data are presented. Due to the small sample size (n = 7), nonparametric statistical analysis was conducted as recommended by Siegal (1957). Qualitative data analysis was then conducted to enrich these findings and to establish themes that were not assessed by the quantitative measures in order to extend and further understand the process of change for participants. As there were seven participants, a case study approach integrating the quantitative and qualitative data for each participant was used to assess and triangulate individual changes across the three time points (pre-, post-program, and six-month follow-up), and to gain a sense of the participants' experience and process of change. Finally, the program evaluation analysis is presented using descriptive statistics for the quantitative component of the program feedback questionnaires and qualitative analysis of the program feedback questionnaires, individual interviews and focus groups.

8.1 Quantitative Analytic Procedure

To test the hypotheses that the program created significant differences for participants in a range of outcomes, Wilcoxon Signed Ranks Tests were performed on the total scores for scales and subscales to examine group difference between pre-, post-program, and six-month follow-up data. A Friedman Test could not be conducted across the three time points due to n being unequal at follow-up (Field, 2009). While this is likely to increase the risk of type 1 errors, due to the low number of participants, this was unavoidable. Effect size was determined by dividing the z value by the square

root of N (number of observations over the two time points) using Cohen's (1988) criteria of .1 = small effect, .3 = medium effect, .5 = large effect.

8.2 Quantitative Results

Table 1 presents the descriptive statistics (pre-program, post-program, six-month follow-up scale and subscale score medians and ranges) of each measure. All seven participants completed the pre- and post-program measures, and five of these participants completed the measures at six-month follow-up.

8.2.1 BPD symptom severity.

Table 1 demonstrates that PDQ-4+ scores revealed a significant reduction in BPD symptom severity ratings at post-program and at six-month follow up compared to pre-program levels, with large effect sizes. Although the BEST measure demonstrated a trend of decreased BPD symptom severity post-program for the total BEST scores, the Thoughts and Feelings subscale, and the Behaviours Negative subscale, with a further decrease for the total BEST at six-month follow-up, these differences were not found to be significant. No change was shown in the Behaviours Positive subscale.

Table 1

Medians and Ranges for Scale Scores at Pre-Program, Post-Program and Six-Month Follow-Up

Scale	Pre-Program (n = 7) *Mdn* (Range)	Post-Program (n = 7) *Mdn* (Range)	Follow-Up (n = 5) *Mdn* (Range)
PDQ-4+			
BPD Symptoms	22a (14-27)	19b (10-26)	15b (11-24)
BEST	33 (17-54)	27 (16-45)	24 (15-35)
Thoughts and Feelings	20 (9-33)	15 (8-25)	15 (10-25)
Behaviours - Negative	9 (5-15)	6 (5-14)	6 (4-9)
Behaviours - Positive	12 (6-12)	12 (7-13)	12 (9-15)
FFMQ	94a (75-139)	109b (92-149)	107b (105-152)
Observing	23a (9-29)	25b (20-35)	25ab (21-33)
Describing	21a (15-37)	32b (20-38)	31a (19-36)
Acting with Awareness	18a (12-27)	22b (17-27)	25ab (14-31)
Non-Judging of Inner Experience	21 (10-28)	21 (12-28)	19 (13-34)
Non-Reactivity of Inner Experience	13a (7-24)	21b (13-26)	20b (13-25)
PRFQ	99 (76-110)	92 (85-107)	96 (93-102)
Pre-Mentalizing	37 (24-41)	34 (31-38)	36 (33-40)
Certainty about Mental States	28 (17-37)	29 (18-38)	20 (17-33)
Interest and Curiosity about Mental States	35ab (20-38)	33a (21-39)	36b (34-40)
DERS	126a (61-157)	93b (70-119)	95b (52-110)
Nonacceptance of Emotion Responses	19 (9-30)	14 (10-24)	13 (9-22)
Difficulties in Goal-Directed Behaviour	16a (11-25)	12b (10-20)	15ab (10-23)
Impulse Control Difficulties	20a (11-25)	14b (11-20)	15b (7-19)
Lack of Emotional Awareness	22a (10-27)	20a (9-22)	15b (7-17)
Limited Access to Emotion Regulation Strategies	24a (13-36)	18b (10-27)	16ab (10-25)
Lack of Emotional Clarity	20 (6-22)	12 (8-20)	11 (5-17)
DSI			
Emotional Reactivity	53a (31-61)	52ab (32-60)	48b (30-55)
Emotional Cutoff	32 (24-56)	33 (24-52)	30 (25-50)
PSI	112 (80-121)	107 (77-118)	107 (89-122)
Lack of Competence	45 (38-54)	42 (35-47)	43 (41-54)
Isolation	17 (13-27)	19 (12-27)	20 (11-24)
Attachment Dysfunction	18 (12-29)	17 (15-26)	18 (15-22)
Role Restriction	25a (16-31)	25ab (15-31)	24b (22-27)
DASS	48a (22-66)	34ab (14-54)	34b (10-52)
Depression	16a (8-20)	8b (4-16)	8b (2-14)
Anxiety	8 (2-14)	14 (2-16)	4 (2-14)
Stress	20a (12-34)	14b (8-24)	20ab (6-26)
ECR-S			
Anxiety	27ab (10-37)	29a (15-35)	28b (17-33)
Avoidance	16 (8-22)	16 (9-28)	9 (8-25)
RQ			
Secure Attachment Style	2 (1-4)	4 (1-5)	3 (1-5)
Fearful Attachment Style	5 (1-6)	4 (2-7)	5 (1-6)
Preoccupied Attachment Style	6 (1-7)	6 (2-7)	4 (1-7)
Dismissing Attachment Style	4 (1-6)	2 (2-7)	3 (1-5)

Note: Medians that have a different subscript significantly differ ($p<.05$) according to Wilcoxon Signed Rank Tests.

8.2.2 Mindfulness.

Table 1 shows that overall mindfulness significantly increased from pre- to post-program and at six-month follow-up compared to pre-program, with large effect sizes. A closer examination of the FFMQ subscales revealed significant increases at post-program, in the observing, describing, acting with awareness and non-reactivity to inner experience facets of mindfulness, with large effect sizes. These effects were generally maintained at the six-month follow-up, although, due to the reduced number of participants responding, only the non-reactivity to inner experience facet of mindfulness significantly differed from pre-program measures.

8.2.3 Parental reflective functioning.

Higher scores on the IC subscale represent increased reflective functioning and for the purposes of this study, the CMS and PM subscale scoring were reversed, so that increased scores indicate a greater level of reflective functioning in all three dimensions. As shown in Table 1, there was a non-significant trend for overall reflective functioning and mentalizing modes of thinking to decrease from pre- to post-program and then increase at six-month follow-up. There was a non-significant trend for lack of certainty about mental states to slightly increase between pre- and post-program, that is being less likely to think that one can be a mind reader, then decrease at six-month follow-up. A significant increase in interest and curiosity in child's mental states was found between post-program and six-month follow-up with a large effect size, following a non-significant decrease from pre- to post-program.

8.2.4 Emotion regulation.

Table 1 demonstrates that overall emotion regulation difficulties significantly decreased from pre- to post-program and at six-month follow-up compared to pre-program, with large effect sizes. A closer examination of the DERS subscales found significant reductions from pre- to post-program in the difficulties engaging in goal-directed behaviour, and difficulties controlling impulsive behaviours when experiencing negative emotions, and improved access to emotion regulation strategies perceived as effective, with large effect sizes. A significant decrease in the lack of awareness of emotional responses dimension of emotion regulation was found between post-program and six-month follow-up, with a large effect size. Due to the reduced number of participants responding, only decreases in the difficulties controlling impulsive behaviours when experiencing negative emotions and the lack of awareness of emotional responses dimensions of emotion regulation significantly differed at six-month follow-up from pre-program measures, with large effect sizes. While the median scores show a decrease from pre- to post-program and a further decrease at six-month follow-up for nonacceptance of emotional responses and lack of emotional clarity, the variation in the direction of change across participant scores meant no significant effect was found.

The DSI scores reflect difficulties in handling affect and for the purposes of this study, the scoring was reversed so that increased scores represented increased emotional reactivity and cutoff. As shown in Table 1, there was a non-significant trend for emotional reactivity to decrease from pre- to post-program and then, significantly decrease at the six-month follow-up compared to pre-program levels, with a large effect size. A non-significant trend was found for emotional cutoff to first, slightly increase

between pre- and post-program, and then to decrease below pre-program levels at six-month follow-up.

8.2.5 Parenting stress.

Table 1 shows that there was a non-significant trend for overall parenting stress, lack of competence, and attachment dysfunction to decrease from pre- to post-program. Due to the reduced number of participants responding at the six-month follow-up, this decrease was only maintained for overall parenting stress. There was a non-significant trend for isolation to increase from pre- to post-program and further increase at six-month follow-up. Although there was no change demonstrated in role restriction from pre- to post-program, a significant decrease was found between pre-program and six-month follow-up, with a large effect size.

8.2.6 Depression, anxiety and stress.

As shown in Table 1, there was a non-significant trend for total DASS ratings to decrease from pre- to post-program and then significantly decrease at the six-month follow-up compared to pre-program levels, with a large effect size. A closer examination of the DASS subscales found significant reductions from pre- to post-program in depression and stress, with large effect sizes although, due to the reduced number of participants responding, at the six-month follow-up only reductions in depression significantly differed from pre-program measures. There was a non-significant trend for stress to increase at the six-month follow-up. There was a non-significant trend for anxiety to increase from pre- to post-program and decrease at six-month follow-up.

8.2.7 Attachment orientation.

Table 1 shows that attachment anxiety did not decrease from pre- to post-program. Instead, there was a non-significant trend for attachment anxiety to first increase post-program, and then show a significant decrease at the six-month follow-up compared to post-program. Attachment avoidance showed no change pre- to post-program, but a non-significant trend demonstrated a decrease at six-month follow-up.

While no significant changes in attachment style were noted pre- to post-program there were trends for participants to rate themselves as generally more secure and less fearful and dismissive, although there was no change in their preoccupied tendencies. At six-month follow-up participants rated themselves as generally less secure and preoccupied, and more fearful and dismissing than at post-program. The RQ also categorically assessed adult attachment styles in close relationships using participant selected paragraph descriptions of the four attachment prototypes (secure, preoccupied, dismissing, and fearful) to classify participants into a discrete attachment category. Table 2 indicates this categorical scoring for each participant at each time period.

As shown in Table 2, the mothers' selection of a general relationship style that best describes them in close relationships found that the fearful attachment description was selected by four participants at pre-program (although one participant had also selected the preoccupied attachment description), two participants post-program, and two participants at six-month follow-up. The preoccupied attachment description was selected by three participants at pre-program (although one participant had also selected the fearful attachment description), by two participants post-program, and by two participants at six-month follow-up. One participant selected the dismissing attachment description pre-program and post-program.

Table 2

Mothers' General Relationship Styles in Close Relationships

Participant	Pre-Program	Post-Program	Follow-Up
Kate	Fearful Preoccupied	Fearful	
Fiona	Preoccupied	Secure	Preoccupied
Aisyah	Dismissing	Dismissing	Secure
Jessica	Preoccupied	Preoccupied	Preoccupied
Alena	Fearful	Fearful	Fearful
Kylie	Fearful	Preoccupied	Fearful
Daria	Fearful	Secure	

It was found that relationship styles had changed to secure attachment descriptions for two mothers following the program (Fiona and Daria), and for one mother six months following the program (Aisyah). Although Fiona selected the secure attachment style description post-program, she rated the preoccupied style higher than the secure style in the RQ rating scale at all time points.

8.3 Qualitative Results

8.3.1 Qualitative analytic procedure.

The qualitative analytic methodology encompassed conducting interviews and transcribing data, reducing data into quotations, coding quotations into thematic categories and sub-categories, and verifying the coded data. Interview questions were reviewed by the research supervisor to ensure that they had the potential to elicit open-ended responses consistent with the evaluation aims. The interviews were conducted by program facilitators to provide participants with a sense of safety and support in order to allow them to feel as comfortable as possible to respond honestly without fear of judgement. Following Patton's (1990) recommendations for a recursive model of interviewing, specific clarification and elaboration probes (e.g., "Can you tell me more about…?"; "Can you tell me what you mean by…?") followed open-ended responses to gain further in-depth information. All audiotaped interviews were transcribed verbatim. A total of 565 quotes, which varied in length from a few words to a paragraph, comprised the data content for analysis.

8.3.1.1 Coding data in thematic categories.

Analysis of data content into interpretable and meaningful themes and categories employed a combined deductive and inductive approach. The deductive approach is theoretically driven and involves using a predetermined set of themes and categories to organise the quotes, while the inductive approach is data-driven and allows the themes and categories to emerge from the quotes (Patton, 1990). Essentialist/realist epistemological approaches to qualitative data analysis theorise motivations, experience and meaning in a straightforward way, where it is assumed that language reflects and facilitates the articulation of meaning and experience (Braun & Clarke, 2006).

Interpretative Phenomenological Analysis (IPA) was employed as the qualitative analytic method for revealing themes and patterns in the semi-structured interviews. IPA aims to explore how participants make sense of, and perceive their personal and social world through individual meanings of personal experience, and is one of the preferred qualitative analytic methods within psychological research (Biggerstaff & Thompson, 2008). IPA involves a two-stage interpretation process, in which the participants are trying to make sense of their world, and the researcher is trying to make sense of the participants trying to make sense of their world (Smith & Osborn, 2008).

8.3.1.2 Presentation of qualitative findings.

The following section presents the qualitative findings for all participants (n = 7) at three time points: Pre-program, post-program, and six-month follow-up. In line with previous recommendations for reporting qualitative research (Krane, Andersen, & Strean, 1997), as much primary data (i.e., quotations) as possible are presented. Thematic categories and the proportion of participants reporting each thematic category are presented in tables organised by the context of the themes. Illustrative quotations accompany these tables explicating each thematic category and sub-category.

8.3.2 Pre-program interview themes.

8.3.2.1 Experiences associated with being a mother.

Table 3 identifies the main experiences of being a mother which have been organised into major themes and subthemes. Major themes included: Love, shame and emotional reactivity.

Love.

Almost all of the participants (n = 6) reported the experience of love as a positive component of being a mother. Five participants reported love to be one of the best aspects of motherhood.

> *The best thing is I think it's filled me with a lot of love. Or rather, I should say, it's brought out all the love that I have to give (Aisyah).*

> *The best thing is that feeling that we're a family unit, and that he's just – when (son)'s happy he feels loved. You can see that he feels really loved and really happy. And if something does happen like when he falls over, we can usually soothe him and ask what he needs or whatever (Jessica).*

Table 3

Experiences of being a mother

Theme	Sub-theme	N
Love		6
	As the best aspect of motherhood	5 (Kate, Fiona, Aisyah, Jessica, Daria)
	Receiving love from own child	4 (Kate, Fiona, Aisyah, Jessica)
	Giving love to own child	3 (Aisyah, Kylie, Daria)
	Desire to be loving with own child	1 (Kate)
Shame		6
	Guilt	4 (Kate, Aisyah, Alena, Daria)
	Not being a good enough mother	4 (Kate, Fiona, Alena, Kylie)
	Regret/Uncertainty about being a mother	3 (Kate, Fiona, Alena)
	Impact of mental health issues on child	2 (Fiona, Kylie)
Emotional Reactivity		5 (Kate, Fiona, Aisyah, Alena, Daria)

Receiving love.

Four of these participants described the significance of receiving love from their children when asked about the best aspects of being a mother.

The best thing is I guess the love they have for me (Fiona).

He's just such a beautiful child. Not just physically, but I feel like he's very sweet, and interacting with him and seeing him – that delight when he gets all up in my grill, when he's in my face and just this big mouth kissing me…There's unconditional love there that feels really very natural and very real (Jessica).

> *Every night my youngest one wraps herself around me and says "Mummy I love you because you're the best mum in the world" (Aisyah).*

Giving love.

Three participants identified giving love to their children as an important aspect of motherhood. When asked what she would like her child to say about her in the present and in the future, Daria demonstrated that she valued the expression of love as an important aspect of motherhood, responding:

> *That he always felt loved (Daria).*

Kate's response illustrated a desire to be loving with her children, and indicated that she felt that she wasn't currently able to express love to them enough.

> *That I was loving. That I could actually be there for them and do things with them (Kate).*

Kylie reported the most surprising aspect of motherhood to be the experience of love she discovered that she had for her child.

> *How much love you have for this little person and that you'd do absolutely anything for them. He is, he's my world and he's the reason I get up every morning (Kylie).*

Shame.

Almost all of the participants (n = 6) described aspects of shame related to their experience of being a mother, which encompassed four thematic categories: Guilt, not being a good enough mother, regret and/or uncertainty about being a mother, and the impact their mental health issues have on their children. The experience of shame involves a negative evaluation directly about the self, often encompassing the total self (i.e., "Who *I* am"), and is generally more painful than guilt. In the experience of guilt the self is negatively evaluated in connection with a behaviour, with the focus of the experience being on the thing done or undone (i.e., "What I *did*") (Tangney & Dearing, 2002). However, in common language usage, individuals often say they feel guilty rather than saying they feel ashamed, as they do not distinguish so carefully the meanings of these emotions (Lewis, 1971; Tangney, 1996; Tangney, Miller, Flicker, & Barlow, 1996). Shame has been found to be a core emotion in BPD and the shame-proneness found in BPD has been considered a contributor to anger and hostility, which are common features of BPD (Rüsch, et al., 2007).

Guilt.

Four participants identified feelings of guilt arising in their experience of being a mother. The perception that they had done things wrong in their role of being a mother entailed an emotional response that tended to result in negative evaluations of self. Aisyah's experience of what she termed guilt related to her reactive emotional response to her children and also to imperfections in her role of the mother. Aisyah describes the guilt she experiences from her behaviours and her experience of shame is illustrated by her questioning why her children would still love her when she turns her back on them in anger.

> *When I get angry with them. I turn my back on them. But then I question – "why would they still love me so much, if I'm that mean?" So it's that guilt of – how could I hate them?...I feel guilty for – them pushing me to that extreme. But then I feel guilty about my anger or hatred towards them. And then I feel guilty about being late, to pick them up. All within a few minutes of each other (Aisyah).*

Kate demonstrated insight into a reactive emotional pattern, in which her primary emotional response of shame led to a reaction of externalised anger towards her child, which then resulted in her feeling even more shame. This is consistent with the theory that individuals experiencing shame initially direct hostility toward the self, which is such a painfully aversive experience that poses such a threat to the self that there is often an inclination to externalise that hostility and blame (Lewis, 1995). The following description was within the context of an interaction between Kate and her oldest child where she experienced what she termed as 'anger' towards him. Kate's experience can be considered as shame-rage response according to Retzinger's (1987) conceptualisation of the shame-rage spiral, whereby shame-rage is conceived as a complex process alternating between shame and rage rather than a simple bodily response of anger or 'normal rage'. Shame acts as both the inhibitor and the generator of anger, with the concealment of shame from one's awareness potentially resulting in inappropriate outbursts that are likely directed at someone less powerful, such as a child. Kate illustrates the resulting "circular feeling trap" (Retzinger, 1987, p. 157) of the shame-rage spiral:

> *I was chasing him, and he lay down on the stairs and I was over the top of him, and I remember he curled up in a little ball, and he was saying that I scared him…I guess when he said he was scared I felt ashamed, but that then made me more angry, again, at him. And it's that – sort of swirling of – I can't deal with*

the fact that you made me feel bad so I hate you even more now. And then I feel guilty. So that pattern, again (Kate).

Although Daria did not explicitly identify feelings of guilt and associated shame, it was implied by her description of when her 7 year old son became aware of her intravenous substance use:

Asking about my scar – my intravenous scar…Initially I lied, saying it was from hospital drips and stuff. He noticed the same markings on other people's arms and then asked me again, and said that he knew that it was from some sort of drug use and he wanted to hear it from me…just a couple of months ago. To me he's still too young to know about my junkie years…But I'd rather he hear the dirty laundry from me than someone else. And he still calls them Cinderellas. He doesn't even know what they're called, Cinderellas you know. He's never seen one in the house or anything but just to know that I put one in myself, it's dirty stigma (Daria).

Not being a good enough mother.

The concept of the 'good enough mother' was raised during the pre-program interview. Four participants reported feeling that they did not consider themselves to be good enough, which tended to be associated with a perception of being a bad mother. As illustrated by the following quotes, the participants' experiences revealed an underlying sense of shame. Two participants referred to their failings as evidence for not being good enough mothers.

You're never going to feel like you're good enough; you're always going to have failures and that you've done something wrong and that you're not doing a good enough job (Kylie).

In relation to the ideal mother, Kate considered herself to be "a failure." When asked about her view of the mother she doesn't want to be, Kate's shame is highlighted by her response of:

> *The one I am now… Faults are always magnified, for me. (Kate)*

Two participants appeared to hold a belief that their child deserved to have a better mother than themselves. Alena's view of her child as 'good' and herself as 'not good enough', resulted in feelings of inadequacy as a mother and an associated sense of shame is implied:

> *I think she could have had a better mum, really. I sometimes think she deserves better. Because of the way she is, I think she's been ripped off a little bit, maybe (Alena).*

Kylie's shame is implicit in her experience of fear; the fear that her child could be taken away due to others judging her to be as bad a mother as she considered herself to be.

> *I feel that voicing how I'm feeling, people are going to look at me differently or judge me or – so I'm very hesitant to open up. And I'm scared that they're going to think that I'm a bad mum and my biggest fear in this world is that someone's going to try and take my son off me. That is my greatest – yeah so I'm scared that by asking for help or saying that I'm struggling, they're going to say I'm not a good enough mum or that – yeah…I just can't help that feeling and that's my biggest fear, is that someone is going to say "you're a bad mum, he deserves better" and my son's gone (Kylie).*

Regret/Uncertainty about being a mother.

When discussing the experience of being a mother, three participants expressed regret or uncertainty about having had children. This appeared to be linked with the difficulties that participants had experienced as mothers, and an underlying sense of shame is implied in the quotes below.

> *I feel like I wasn't the ideal candidate to have children, that I didn't recognise my particular makeup would make it that much harder (Fiona).*

> *I don't think it suits me. Somebody actually said to me when I had her and was sitting out at dinner one night she goes "I can't believe you're a mum, I never thought you'd be a mum". So – but I was still surprised sometimes and to be perfectly honest she wasn't planned. Her dad and I – it did happen and that was okay that was good. I was undecided as to whether I would have children, and I'm still not sure sometimes that it suits me, and sometimes maybe certain people shouldn't be parents and I sometimes think "is that me?" (Alena)*

It appeared that Kate experienced her children's expressed needs as demanding and encumbering. Her perceived inability to cope with these difficulties led her to express regret about having had children:

> *To me, the whole thing about being a mother seems to be a complete imposition to me. It's like everything they ask just grates on me….Just them wanting a part of me...anything that just seems to require something of me, I find really difficult...I don't think I would have ever had them, to be honest (Kate).*

Impact of mental health issues on their children.

Two participants expressed concern about the impact their mental health issues were having on their children. Although they did not explicitly state that they experienced a sense of shame, this was illustrated by the great concern expressed that their own difficulties are negatively impacting on and even damaging their children.

> *The worst thing is feeling I'm moulding them in the wrong…that I'm damaging them (Fiona).*

When Kylie discussed what she would love not having to do as a mother she reported:

> *Not have to worry about how my mental health's affecting him. Because I know it does affect him, and I don't think that's fair. He's a little boy; he should be able to be a child without having to worry about his mum, what's going on with his mum… I do struggle and I don't feel that I'm doing a good enough job (Kylie).*

Emotional reactivity.

The majority of the participants (n = 5) described negative emotional reactivity as a component of their experience of being a mother. It appears that their emotional reactivity contributes to a sense of shame, where participants tended to perceive themselves as not being a good mother. Kate reported frequent interactions with her children resulting in emotional reactivity that she considered to be low points for her as a mother.

> *It's things like I'll get angry and they might have done something so I'll call them a name, or – things like that. Or I've hit them or shoved them or – when one of them was much younger and he was mucking around I picked up his school bag and held it over his head (Kate).*

Aisyah and Alena's low points as mothers were also related to their negative emotional reactions in response to their children's behaviours.

> *I got so frustrated with my eldest one that I just said "forget it, I've had enough. Don't call me Mummy anymore; you're on your own" (Aisyah).*

> *When I'm reacting to a behaviour and I just don't stop. And I know that I'm berating and I just can't stop myself. That's happened more than once, but it's always the low point. That's probably the worst I'd say. I mean a smack sure but that doesn't happen very often (Alena).*

Daria envisaged her son would say that as a mother she is "crazy" and related this to her emotional reactivity.

> *The – emotional mess. One minute I'm yelling, the next minute I'm laughing (Daria).*

These major themes that emerged in the pre-program interviews in relation to participants' experiences of being a mother (love, shame, emotional reactivity) highlight the significant impact that emotions have on these mothers. The emotion regulation and interpersonal difficulties experienced by people with BPD can develop from difficulties in dyadic regulation with primary attachment figures (Mosquera, Gonzalez, & Leeds, 2014). The next section explores participants' attachment experiences within their family of origin.

8.3.2.2 Participants' experience of parenting in their family of origin.

Table 4 identifies the main experiences of parenting in participants' family of origin, which have been organised into major themes and subthemes. The major theme for all participants was low parental affection, with subthemes that included disengaged parenting style, authoritarian parenting style, absent parent and overly critical parent.

Low parental affection.

Emotional and physical neglect in childhood are common experiences found amongst BPD patients, and inconsistent treatment by a female caregiver and emotional denial by a male caregiver have been found to be significant predictors of the borderline diagnosis (Zanarini, 2000). All seven participants reported experiencing low parental affection in their own childhoods, which incorporated four thematic categories: A parent with a disengaged parenting style, a father with an authoritarian parenting style, an absent parent, and an overly critical parent.

Table 4

Experiences of parenting in family of origin

Theme	Sub-theme	N
Low parental affection		7
	Disengaged parenting style	
	Mother	5 (Kate, Fiona, Aisyah, Alena, Kylie)
	Father	2 (Alena, Daria)
	Authoritarian parenting style	
	Father	4 (Kate, Fiona, Aisyah, Daria)
	Absent parent	
	Mother	1 (Daria)
	Father	1 (Kylie)
	Overly critical parent	
	Mother	2 (Jessica, Kylie)
	Father	1 (Fiona)

Disengaged parenting style.

Almost all participants (n = 6) portrayed a disengaged parenting style from at least one parent when describing their experience of parenting in childhood. The low control and affection associated with a disengaged parenting style can result in disrupted attachment and limit the child's ability to form a personal identity (Teyber & McClure, 2011), contributing to the unstable sense of self which is a characteristic of BPD. Five participants reported this style of parenting from their mother and two participants reported this from their father. Four participants described their parent's emotional disconnection.

> *They worked from home, so she was always quite busy and she was quite distant because – or I assume because – I'd had a sister who passed away before I was born, and I think she sort of held me and my brother at arm's length because of that (Kate).*

> *As a young child, I was the youngest, so I got a bit more time with her. I enjoyed that but – when my sister got ill everything changed…[she was] distant and – I was left to my own devices and there was a lack of boundaries and I never felt loved (Fiona).*

> *I think my parents just felt that as long as we were alive they'd done a good job (Alena).*

Aisyah and Daria who attended boarding schools indicated an experience of physical abandonment and parents not being present.

> *Even when I was back in Singapore with mum she was never really there. She was always at work, or busy with her tennis tournaments or squash tournaments, all that sort of stuff (Aisyah).*

> *There were mainly babysitters, and he was a very professional man. Full on into his work and it was generally babysitters, after school care, and I went to private school so a lot of the times it was in the boarding as well (Daria).*

Authoritarian parenting style.

Four participants described father figures with an authoritarian parenting style. The lack of emotional support and affection associated with this disciplinarian approach is commonly reported to disrupt the development of attachment security, so that the child learns to hide any indicators of vulnerability from their parents and eventually from themselves (Teyber & McClure, 2011). This can result in a fear of disapproval or rejection, with these children often internalising anger and having difficulties coping with frustration that may often result in anger outbursts, a feature of BPD (Teyber & McClure, 2011).

He just didn't really have any involvement, unless he was disciplining you (Kate).

Before my sister got ill he was – we were afraid of him but he took us places…as I grew up and my sister got ill it was just fear (Fiona).

My fear of spiders, arachnophobia, came from that time of my life because I was locked up in the garden storeroom as punishment. He wasn't allowed to lay a finger on me, to smack me anywhere. So I got locked up in the garden shed thing…He had a violent temper. We discovered when he smacked my sister so hard 'til she was bleeding because she embarrassed him at the kindergarten one day, so he dragged her home and smacked her. Soon after that I was sent to boarding school (Aisyah).

Absent parent.

Three participants reported having an absent parent, which may have resulted in a sense of abandonment and contributed to the development of BP traits. Emotional and/or physical neglect in childhood is reported by 92% of BPD patients and has been found to be significantly more common in BPD compared to other personality disorder controls (Zanarini, 2000).

I wasn't raised by my mum – I didn't meet her 'til I was fourteen (Daria).

As it turned out he wasn't my dad he was my step-father…I was sixteen, found out by accident. He wasn't really a father because of that…before I realised, when I was still a kid – I always put it down to my sister's his favourite and I'm my mum's favourite (Aisyah).

My Dad wasn't in the picture. My stepfather was around from when I was about six. But that was a very complicated relationship in itself, they were together but they didn't actually live together. So I've never had a proper understanding of a mother-father-children relationship (Kylie).

Overly critical parent.

Three participants reported having an overly critical parent. Fiona experienced constant criticism from her father, while Kylie and Jessica experienced a high level of criticism from their mother.

> *We were criticised and - nothing we ever did was good enough. And we were compared constantly to our cousins (Fiona).*

> *For everything she blamed me, my godmother committed suicide when I was nine and my mother blamed me for it…And everything that went wrong was my fault and when she was in a bad mood it was all my fault, I was the reason all her problems were there (Kylie).*

> *She was very loving but she could be very critical (Jessica).*

An exploration of participants' experiences of parenting in their family of origin revealed a pervasive theme of low parental affection. Participants' early experiences with their caregivers (disengaged or authoritarian parenting styles; an absent or overly critical parent) appear to have resulted in an attachment system dysfunction. This finding is supported by participants' (n = 7) identification with insecure attachment styles pre-program, as measured by the RQ.

8.3.3 Post-program interview themes.

8.3.3.1 Changes in the experiences associated with being a mother.

Table 5 identifies the main changes in the experience of being a mother, which have been organised into major themes and subthemes. Major themes included: Increased reflective functioning, improved self-concept and increased self-care.

Increased reflective functioning.

All seven participants described increased reflective functioning following the program, which encompassed three thematic categories that are components of mentalization (Allen, Fonagy, & Bateman, 2008): Interpersonal reflection of cues, reflection on their children's internal mental states, and self-reflection.

Interpersonal reflection of cues.

Five participants demonstrated an increased ability to reflect on interpersonal cues such as behaviour or context to understand and interpret their own and others' underlying mental states. Alena described this occurring in a situation where she felt her friend wasn't responsive in providing assistance when her car broke down.

> *I just took a step back, waited it out more than I normally would. Because before like "I don't care she's not my friend anymore" but this time – I don't want to lose this friendship so I've just got to really step back, bide my time, wait, try and think clearly, because there's a pattern going on with me losing friends, and maybe it's the way I deal with these scenarios. To a point, I mean it takes two, but to a point. So just not getting so heated up about things and not playing the victim and trying to realize that other people have their own issues as well, it may not be always to do with me specifically (Alena).*

Table 5

Changes in the experience of being a mother

Theme	Sub-theme	N
Increased reflective functioning		7
	Interpersonal reflection of cues	5 (Kate, Fiona, Aisyah, Jessica, Alena)
	Reflection on child's internal mental states	5 (Kate, Fiona, Aisyah, Kylie, Daria)
	Self-reflection	4 (Kate, Fiona, Aisyah, Daria)
Improved self-concept		6
	Reduced self-criticism	5 (Kate, Aisyah, Jessica, Kylie, Daria)
	View of self as good enough mother	4 (Fiona, Aisyah, Jessica, Daria)
	Increased self-efficacy	3 (Kate, Jessica, Kylie)
Increased self-care		5
	Increased self-nurturing	5 (Kate, Fiona, Aisyah, Jessica, Alena)
	Increased self-compassion	3 (Fiona, Aisyah, Alena)
	Lessened demand on self	2 (Fiona, Aisyah)

Jessica described a situation where she had a conflict with her sister and was able to stand up to her while also identifying her sister's behaviour as a reflection of her underlying mental state.

> *She's going through some very difficult stuff so I think she was feeling a bit negative in general and seeing the worst side of everything (Jessica).*

Fiona found that she was now "seeing things from their point of view". Kate reported feeling more protective towards her son as she became more aware of his perspective of the world and an increased ability to reflect on his behaviours within that context.

> *Well it's better for me. But it also means that I can see in other people when they get frustrated and upset, that that makes me feel more – like you know leave him alone. Whereas before I was like "yeah he's annoying isn't he" (Kate).*

Reflection on their child's internal mental states.

Five participants described how they had become increasingly reflective of their children's internal mental states, which tended to be associated with increased awareness. This increased reflection resulted in an improved understanding of their children and reduced reactivity in response to their behaviours.

> *I seem to be more able to be – either calm, or reflect later on if I'm not. And a bit more aware of what the kids are feeling or thinking at the time, that sort of – because I just have more of an awareness…I give more, sort of leeway to my youngest child because he's got special needs sort of thing. I try to process that a bit more. I go "okay he's not necessarily trying to wind me up", and sort of be aware that he's got his own, sort of world that isn't necessarily the same as everyone else's (Kate).*

A bit more aware of the kids…Being more aware of why they do things, or react the way they do. I'm less reactive towards that, unless my tolerance and immunity is that low – then yes I do react in an irrational way. But I find more and more now that I'm stepping back and saying "okay, (daughter)'s being difficult and screaming back at people because she's tired, simply tired" (Aisyah).

Self-reflection.

Four participants reported increased self-reflection following the program, with one participant relating this to an increased reflection on her child's internal mental states.

I'm trying to be more aware of myself (Kate).

[I'm] just really understanding my nature and how parenting is particularly challenging for me (Fiona).

Now I'm more inquisitive about (son)'s way of thinking, and [his] mindfulness now. Normally I'm trying to learn mine, but I'm also...whenever I think about it for myself I then think about it for my boy. So now I'm mindful of his mindfulness (Daria).

Improved self-concept.

Almost all participants (n = 6) described improved self-evaluations, particularly in relation to how they perceived themselves as a mother. This improved self-concept involved three thematic components: Reduced self-criticism, a view of self as being a good enough mother, and increased self-efficacy.

Reduced self-criticism.

Five participants reported that they were less critical of themselves than they were prior to the program, which appeared to be associated with sharing experiences with the other mothers, increased reflective functioning and self-acceptance.

> *I'm not as critical or judgmental. I'm more open to what's around me, in terms of what's influencing my ability to be a mum (Aisyah).*

> *I feel far less judgmental about myself knowing that I'm not the only person who feels that way (Jessica).*

> *I'm not as harsh on myself now. I think that's because I give myself time to make alterations or changes before I say something that I'll regret (Daria).*

View of self as a good enough mother.

Four participants identified with the 'good enough mother', which indicates that the program resulted in participants developing more realistic views of themselves as mothers.

> *Yeah I'm good enough. I'm good enough. Definitely good enough (Fiona).*

> *The 'good enough' mum is the mum who does the best she can, at that time, given the circumstances and – towards them, everything that she has…I'm a good enough mum (Aisyah).*

> *I don't feel like I'm bragging or over-stepping myself to say no I am a good enough mum. I do provide the love and the physical needs that are enough, and no I can't buy fancy matching clothes and that kind of thing. And I haven't got the guts to have gone to a playgroup yet but I can go to story time and that kind of thing. I like the idea because I feel like I can manage that, being good enough, yeah (Jessica).*

Increased self-efficacy.

Three participants reported increased self-efficacy in themselves and in their abilities as a mother. This outcome was associated with increased self-confidence and an improved experience of being a mother. This is supported by the significant increase in the sense of competence in parenting capacity, as measured by the PSI, following the MPG-BPD program.

> *I have more self-belief. I still have the doubt, but it's not as big as it was (Kylie).*

> *I've felt more stable. A bit more confident in my parenting. I still have a lot of issues that I need to go through personally with a psych one-on-one. But I generally feel a little bit more confidence in myself and my ability to be there for (son) (Jessica).*

> *I'm enjoying it more and I'm becoming more confident in myself as a mum and what I say and how I raise him (Kylie).*

Increased self-care.

Five participants reported that the program resulted in increased self-care, entailing self-initiated practices that foster personal health and well-being. With its focus on self-nurturing and self-compassion, the program provided participants with self-care skills and a rationale to utilise these.

Increased self- nurturing.

All of these five participants reported the use of self-nurturing, treating themselves with care and respect when experiencing a low mood or distress.

> *If I'm actively withdrawing and stuff like that I will try to make sure that I have time to go and see friends. I've been trying to do art again, so trying to schedule in those regular activities that help pull you out of yourself (Kate).*

> *There have been occasions where I've gone "no, sit back, there's nothing you can literally do, so you just have to put it aside, put it on a backburner, not worry about it, go and do something with – take (son) for a walk to the park, read a fiction, read a fashion magazine, do some sketching" (Jessica).*

Aisyah was in the process of building a house for her family during the program and described an instance following the program when she felt overwhelmed and distressed by all the things that she had to do. Her response to this illustrated that she had adopted a self-nurturing approach to care for herself.

> *There were a couple of things that I thought of and straight away the heart palpitation and the shortness of breath came on, and I knew, "okay I need to give this all a break, not think about any of this", and rang (husband) and said "today is a no-go day"... I took a conscious decision to not deal with any of it…I just made that whole day a non-day. No building no nothing. And I sat down, I went to my favourite supermarket – and bought my favourite foods, cooked up something, it was really nice and just played with the dog in the backyard (Aisyah).*

Increased self- compassion.

Three participants described an increased sense of kindness and understanding towards themselves, and as expressed by Fiona, had developed "more compassion for myself".

I'm more forgiving….Particularly myself, but also to others (Aisyah).

Alena described a self-compassionate approach rather than self-judgement when she reverts to her previous parenting behaviours.

I'm still having little lapses, but when I do it just makes me more aware of what I need to do next. I like to think that every little lapse is actually taking me somewhere (Alena).

Lessened demand on self.

For two of the participants, this increase in self-compassion was accompanied by a reduction in the demands that they placed on themselves as mothers.

I was always trying to be everything to them. So I'm not trying to be everything anymore (Fiona).

I can't be everything. I can try! Doesn't mean that I'll be successful. But I also accept the times when I'm not going to be successful, and then I step back and let someone else take over (Aisyah).

In summary, the most frequently reported outcomes of the program related to the experience of being a mother were increased reflective functioning, improved self-concept, and increased self-care.

8.3.3.2 Changes in relationship interactions.

Table 6 identifies the main changes in relationship interactions, which have been organised into major themes and subthemes. Major themes included: Improved mother-child relationship and improved interpersonal relationships.

Improved mother-child relationship.

As a result of undertaking the MPG-BPD program all seven participants reported improved relationships with their children, comprising of five thematic categories: Increased awareness of their children's needs, increased enjoyment, improved communication, increased tolerance, and attempting repair and restoring relationships.

Increased awareness of child's needs.

All seven of those participants described having an increased awareness of their children's needs since the program. This outcome seemed to result from the combination of attachment psychoeducation and the mindfulness focus of the MPG-BPD program.

> *Physically I'm always present, there for him physically, but to be there for him – to be mindful with him as well. And I'm able to do that more since having been in the group (Jessica).*

> *Just being more mindful of their needs. Not just their physical needs but the emotional needs (Aisyah).*

> *I think the importance of mindfulness, especially in parenting. Because it's not just about you, it's that mindfulness of your kids' needs. Of what's affecting them and their happiness. Mindfulness of what makes them happy (Aisyah).*

Table 6

Changes in relationship interactions

Theme	Sub-theme	N
Improved mother-child relationship		7
	Increased awareness of child's needs	7 (Kate, Fiona, Aisyah, Jessica, Alena, Kylie, Daria)
	Increased enjoyment	5 (Kate, Fiona, Jessica, Alena, Kylie)
	Increased communication	4 (Fiona, Aisyah, Alena, Daria)
	Increased tolerance	3 (Kate, Aisyah, Alena)
	Attempting repair and restoring relationships	3 (Kate, Fiona, Aisyah)
Improved interpersonal relationships		5
	Increased assertiveness	3 (Jessica, Alena, Kylie)
	Implementing interpersonal boundaries	3 (Fiona, Kylie, Daria)

Fiona reported previously feeling uncomfortable 'bragging' about her children and tended not to demonstrate her pride in them, in a sense reflecting her family of origin where criticism was prominent, but not praise or pride. Whereas, following the program she identified this as something that was changing, as she could see her children wanted her to show pleasure in them and their accomplishments.

> *I may be coming a little bit more - taking a little pride, being a bit more visible about that. Just a slight bit, like if they have an achievement (Fiona).*

Increased enjoyment.

Five participants noticed that their experience of being a mother and the enjoyment of their children had improved following participation in the program. This appears to be related to the mothers feeling more relaxed and less anxious.

> *I feel a little bit more relaxed. Because I feel a little bit less anxious in myself, that allows me to just enjoy everything a little bit more, which includes interacting with (son) (Jessica).*

> *Because I can relax a bit more with the things that (son) does. I'm not as tense about the whole thing all the time. So if I can relax more with the stuff that he's doing, then he can play and be happier. So yeah I think in that sense it makes it more pleasurable (Kate).*

> *There are things that are already better, like we laugh a lot more; we're friendlier (Alena).*

Improved communication.

Four participants reported that communication between themselves and their children had increased and had also become more meaningful. This outcome appeared to be associated with participants' expressing curiosity about their child's experience and also explaining to their child their own experience. Fiona described being upset and angry after a funeral due to issues with her husband's family and letting it out at home. She realised this was impacting her daughter and explained her behaviour. This resulted in relationship repair and increased connection with her daughter.

> *I felt that my older daughter needed to know a reason for my rage, and I gave it to her. It was a very hard conversation (Fiona).*

Communication – I mean she's six, but communication is better…she's always been allowed to express herself, but maybe she hasn't really realised that, if that makes sense (Alena).

There's been a couple times now…I'll ask one of them "so how do you feel about doing this? (daughter), how does it make you feel?" So I'm prompting them (Aisyah).

Increased tolerance.

Three participants reported that tolerance for their children's behaviours had increased, which was particularly challenging for Kate before the MPG-BPD program.

[I'm] tolerating stuff, like especially (son)'s – behaviour. More sort of try to focus on the big picture (Kate).

Tolerance. I was less tolerant before the group (Aisyah).

Attempting repair and restoring relationships.

Three participants had applied the Circle of Security (COS) 'Circle of repair' model in attempting to repair ruptures in relationships with their children and address their attachment needs.

[I'm] recognising the need for repair, and doing something about that (Kate).

You've given me skills how to repair…I still have difficulty at times – but I always get right back in there and repair (Fiona).

I think one thing I have learnt is that mending is the most important thing (Aisyah).

Improved interpersonal relationships.

The majority of participants (n = 5) also reported improved relationships with others in their lives, which appeared to be related to an increase in assertiveness and the development and implementation of interpersonal boundaries.

Increased assertiveness.

Three participants reported that they had become more assertive since the program, which for Kylie and Jessica seems associated with improvements in self-concept.

> *I've got the belief in myself as a parent. Because I am noticing more and being in the moment and enjoying it, so I'm able to back myself up and say "well I'm his parent, I say what goes, and if you don't like it then that's your problem" (Kylie).*

> *I sort of had to stand up to my sister, which I don't usually do, and she did end up apologizing and saying "I'm sorry"...I don't think I would have been able to be as assertive with her before I'd done the group. I think I was able to be more assertive with her from having done the group (Jessica).*

Implementing interpersonal boundaries.

Three participants described implementing interpersonal boundaries following the program, which appears to be an aspect of self-care.

> *I'm being in the moment more; I'm not putting up with shit from anyone. Like I've got a friend who's a lot of drama, and I just haven't been going there (Kylie).*

People come and ask me to go score for them. And usually I'll go and score for them, next thing you know they're shouting a taste. Well now I've just told them that I'm not in that space, and I don't score for them so I'm not tempted (Daria).

In summary, improved mother-child relationships and improved interpersonal relationships were the most frequently reported program outcomes related to participants' relationship interactions.

8.3.3.3 Changes in mood and emotions.

Table 7 identifies the main changes in mood and emotions, which have been organised into major themes and subthemes. The major theme was increased affective stability.

Increased affective stability.

As a result of the MPG-BPD program, participants reported changes in mood and emotions that were synonymous with increased affective stability, which comprised five thematic categories: Improved emotion management, management of emotions using mindfulness, reduced reactivity of mood, reduced severity of mood and emotion, and reduced guilt/shame.

Table 7

Changes in mood and emotions

Theme	Sub-theme	N
Increased affective stability		7
	Improved emotion management	7 (Kate, Fiona, Aisyah, Jessica, Alena, Kylie, Daria)
	Managing emotions using mindfulness	7 (Kate, Fiona, Aisyah, Jessica, Alena, Kylie, Daria)
	Reduced reactivity	7 (Kate, Fiona, Aisyah, Jessica, Alena, Kylie, Daria)
	Reduced severity of mood and emotion	5 (Kate, Aisyah, Jessica, Alena, Daria)
	Reduced guilt/shame	3 (Kate, Jessica, Alena)

Improved emotion management.

With its focus on the identification, reflection on, and acceptance of emotions, the program provided participants with emotion management strategies. As a result, all participants reported increased capabilities for managing emotions following the program. This outcome is supported by the significant decrease in emotion regulation difficulties, as measured by the DERS, from pre-program to post-program.

I've got skills to centre and balance myself back at those times (Fiona).

I'm more able to manage my anxiety (Jessica).

I try and take a breath if I'm about to lose it. I was trying to before, but I'm being more mindful of doing it now (Kylie).

Before I'd get drawn in a little bit more with the whole thing…and wherever that was taking me I would allow that to happen. Whereas now I'm a bit more recognising it and able to do things that I know would help to make me well, or help to try and shift that mood (Kate).

Management of emotions using mindfulness.

Those participants (n = 7) particularly identified the effectiveness of utilising mindfulness for their emotion management. Following the program, participants appeared to feel more capable with applying mindfulness when experiencing strong or difficult emotions.

With situations where I was upset, I would try to bring the idea of mindfulness to my mind (Kate).

I understood the theory, but really had the chance to practice it. And the thing is remembering it. The whole point is not to get overwhelmed by your emotions, but if you are overwhelmed by your emotions, one of the first things that goes out the door is the mindfulness...whereas now I feel a bit more like "okay I'm getting overwhelmed, mindfulness is there as a tool – I can do it". I'm not an expert meditator or a Zen master, but it's something I can do (Jessica).

The thoughts and acceptance stuff really got to me more than anything else. So I think just focusing on that, and even when I was doing any mindfulness practice – again I did the leaves on a stream, that was a good one for me, and just letting things go. I think that more than any has kind of made a difference…I'm not mulling on things as much, things that don't matter (Alena).

Whether I even wanted to use [substances], [the decision] had been already made for me, without my conscious being there; it's a totally different ballpark now that I'm being mindful. I'm definitely not one hundred per cent got a grasp on being mindful, and with my aggressive emotional state it's had a real impact there. Yeah it's helped me (Daria).

Reduced reactivity.

Additionally, all participants described a reduction in emotional reactivity following the program. This data indicates that the improved ability to manage emotions may be associated with the outcome of reduced reactivity of mood, and that the MPG-BPD program could be effective for reducing BPD symptomatology considering that a criterion of BPD is affective instability due to a marked reactivity of mood.

> *There is less of the losing it. There is more effort at preventing losing it, if that makes sense (Alena).*

> *I can say "I'm feeling a bit overwhelmed, that's just a thought, everything's actually fine. It's very unlikely that I am going to trip over, knock myself out and (son) will be by himself for the day and he will get sick, might get hurt" or something like that. "That's really a paranoid thought and it's not very likely so just let it go past and stop worrying about it." That is – it pushes back a bit of the overwhelming – it means I can step back from the emotions a bit. And before I used to have to use drugs to do that, whereas now I can do it a little bit better without having to. So yeah it's definitely made a difference (Jessica).*

> *I'm able to step back a little bit more than I used to be, and – sometimes recognise moods for what they are – that they're just moods (Kate).*

> *In the past if I really got angry or something I probably would have just thrown something or broken something, but now I just sit there and glare, evil stare…Still angry, less reactive. Less impulsive (Aisyah).*

Reduced severity of mood and emotion.

When asked whether they had noticed any changes in their mood, the majority of participants (n = 5) identified a reduction in the severity of their moods and emotions.

This outcome appears to be associated with increased mindfulness and improved emotion management.

> *[My mood] is less extreme, and when it does go to extreme I am aware of it going into extreme, and I then choose. I can mindfully choose to either allow myself to do that extreme thing, or bring it under control (Aisyah).*

> *I'd say the severity of it had changed…I guess generally I can feel a bit lighter because I'm not always feeling shitty about stuff I've done with the kids, or not done. I think that contributed a lot to my moods (Kate).*

> *So my mood is – it's somewhat improved. Still varies a lot, still goes up and down a lot, but I'd say there's some improvement in it, or in me being able to manage it (Jessica).*

Reduced guilt/shame.

Three participants experienced a reduction in guilt following the program. Two of these participants (Alena and Kate) had reported feelings of guilt/shame in their experience of being a mother prior to the program. Alena described how having an increased ability to manage her emotions, particularly guilt, allowed her to consciously choose different ways to respond to and interact with her child. She attributed this outcome to the mindfulness of difficult thoughts and acceptance components of the MPG-BPD program.

> *Because I felt guilty about everything I just dealt with things a bit poorly I think. Guilt drove me in a lot of ways…just acknowledging that I don't need to feel so guilty opens things up a bit (Alena).*

> *I think it's just the lack of guilt. Whatever it is I'm doing – because as I said the thoughts and acceptance stuff really got to me more than anything else (Alena).*

Kate described her experience of being a mother to have improved following the program, relating this to a lessened sense of guilt associated with decreased reactivity and an ability to identify and repair ruptures with her children.

> *I can be less guilty about it, and that sort of stuff, it's – in that sense less negative, but I still find it a challenge…I'm a bit more tolerant and that means less of the behaviours that I have to feel guilt about and also that I can more recognise when I need to repair. Both of those sort of reduce those negative sort of feelings and outcomes that you get (Kate).*

Although Jessica did not overtly express feelings of guilt prior to the program, she identified that "I'm not feeling the same sort of guilt that I had before".

Considering all participants (n = 7) reported the program outcome of increased affective stability, there is evidence that participation in the MPG-BPD program can result in decreased BPD symptomatology.

8.3.3.4 Changes in mindfulness.

Table 8 identifies the main changes in mindfulness, which have been organised into major themes and subthemes. The major theme was increased mindfulness.

Increased mindfulness.

As a result of doing the MPG-BPD program, all participants reported increased mindfulness, which encompassed five thematic categories: Increased awareness, present moment focus and acceptance, and reduced reactivity and impulsivity. This outcome is supported by the significant increase in levels of overall mindfulness, as measured by the FFMQ, from pre-program to post-program.

Table 8

Changes in mindfulness

Theme	Sub-theme	N
Increased mindfulness		7
	Awareness	7 (Kate, Fiona, Aisyah, Jessica, Alena, Kylie, Daria)
	Reduced reactivity	6 (Kate, Fiona, Aisyah, Jessica, Kylie, Daria)
	Present moment focus	4 (Aisyah, Jessica, Alena, Kylie)
	Acceptance	3 (Fiona, Aisyah, Alena)
	Reduced impulsivity	4
	Reduced substance-use	2 (Jessica, Daria)
	Reduced gambling	1 (Alena)
	General	1 (Aisyah)

Awareness.

All seven participants reported increased awareness, which appears to have resulted in a broad awareness of self, others, and experience. Through this awareness, participants were able to respond to situations, thoughts and emotions in a more considered way and improve their experience as a mother and more generally. This result is supported by the significant increase in the acting with awareness facet of mindfulness, as measured by the FFMQ, from pre-program to post-program. Daria identified that "my mothering has differed, because I'm actually aware".

> *I think I've taken it beyond just doing mindful exercises, it's part of a lifestyle, the way you experience life. If you experience it mindfully it's so rewarding. You feel more complete, because you've experienced everything, because you're aware of everything (Aisyah).*

There's more situations that I could probably contain myself in now, and be more self-aware than not, you know some situations that I might have just lost it in before…I do it less now, or can detach myself (Kate).

Well I'm very aware of all the maladaptive thoughts, and I would say that it has shifted (Fiona).

Taking the time to notice and be in the moment proves to me that I'm not as bad a mother as I believe and as I let others make me out to be at times (Kylie).

Reduced reactivity.

Six participants described a reduction in reactivity due to mindfulness, which appears to have allowed them to pause and consciously consider situations before responding to them. This outcome is supported by the significant increase in the non-reactivity to inner experience facet of mindfulness, as measured by the FFMQ, from pre-program to post-program. This indicates that mindfulness is an effective approach for reducing the extreme reactivity that is characteristic of BPD.

I'm not as reactive. I'm now sitting back and trying to be mindful of what are the factors that are affecting the situation (Aisyah).

I'm not so reactive. Before I react I try and at least take a breath and re-think (Kylie).

Keeping myself occupied and not letting that auto-pilot allow to take over. Especially in those times of need where I'm vulnerable…a lot more conscious of the thoughts…they're not knee-jerk responses, they're conscious responses which is what I've wanted (Daria).

It's good because it puts a stop on things, in a way. It draws your attention to something outside of yourself for a moment. Or if it is still with inside yourself it allows you to see it as almost separate for a second (Kate).

I feel more balanced in that regard…Emotionally balanced (Fiona).

Present moment focus.

Four participants reported experiencing increased present moment focus, which was accompanied by lessened rumination and worry, increased enjoyment of their children, and an improved overall experience.

I try and be more present…Even just sitting there reading with him, I take in the moment that we're just sitting, we're still, and we're just doing something together, rather than me trying to do twenty different things at once (Kylie).

Just slowing down, and trying to focus on what I'm doing at the time…trying to focus on what I'm doing now and not always worry about later, tomorrow, next week, has started to work for me (Alena).

Even if I am listening to music, I'll listen to the music and just observe things around me, just feel – step back from – yeah become mindful of what I'm doing, be centred on what I'm doing, be centred in the real world. Not be off with the fairies letting things bother me, worrying about something negative I heard last night…And just go, "well it doesn't matter because right now I'm here with (son), we're going to the grocery shop. I've got my cloth bag, I'm listening to this musician, he's tucked up with his little blanket so his little feet are warm", thinking about those things (Jessica).

Acceptance.

Three participants described increased acceptance as an outcome of the MPG-BPD program, which appears to have contributed to improved emotion management and an improved self-concept.

I'm more accepting of myself (Fiona).

I've really started to – a couple of the methods that were suggested in some of the reading, which is the "Oh here's that old if I were with (ex-partner) story" kind of thing – so that one and you have to go "ah ha", have a bit of a giggle at it, so just accepting that. That it still hits me in the gut there, but it doesn't linger. So there's that, and just acknowledging that it's probably going to keep happening (Alena).

Reduced impulsivity.

Alongside the reduction in reactivity, the mindfulness focus of the program appears to have resulted in reductions in impulsivity for some participants (n = 4), also resulting in reduced substance-use (n = 2) and reduced gambling (n = 1). This outcome is supported by the significant decrease in ratings of difficulties controlling impulsive behaviours when experiencing negative emotions, as measured by the DERS, from pre-program to post-program. This further indicates the potential efficacy of the MPG-BPD program for reducing BPD symptomatology.

I feel like I've been able to use those mindful techniques to give myself a bit of space...before I was using drugs to do that, to put some space between me and the rest of the world when it became too overwhelming and intense and just too much. So I do feel like the mindfulness feeds into the sobriety in quite a positive cycle in a way (Jessica).

With this sort of tool this is really – I don't really know how to work it out but this really had a direct impact on my substance abuse (Daria).

I'm doing a few things all at once, like the whole gambling thing, that's happened and that's a success. And it means there's a little bit more financial freedom too…When I wasn't feeling well a little while ago it would pop into my head a bit more, I felt like I was a bit at risk. But it just made me more aware. I just fought against it a little bit harder (Alena).

The mindfulness component of the MPG-BPD program resulted in all participants (n = 7) reporting increased mindfulness as a program outcome.

8.3.4 Six-month follow-up interview themes.

One participant (Daria) did not complete the six-month follow-up interview due to personal difficulties she was experiencing at that time. The other six participants attended interviews six-months after the MPG-BPD program.

8.3.4.1 Changes in reflective functioning.

Table 9 identifies the main changes in reflective functioning, which have been organised into major themes and subthemes. The major theme was increased reflective functioning.

Increased reflective functioning.

The six participants who completed the six-month follow-up interviews described increases in reflective functioning at post-program and at six-month follow-up. This data indicates that increased reflective functioning is an outcome of the MPG-BPD program that is maintained six-months later.

Table 9

Changes in reflective functioning

Theme	Sub-theme	N
Increased reflective functioning		6
	Self-reflection	6 (Kate, Fiona, Aisyah, Jessica, Alena, Kylie)
	Reflection on internal mental states	6
	Child	6 (Kate, Fiona, Aisyah, Jessica, Alena, Kylie)
	Others	3 (Fiona, Aisyah, Alena)

Self-reflection.

Four participants (Kate, Fiona, Aisyah, Daria) explicitly described increased self-reflection post-program, and this was identified by an additional three participants six months later (n = 6). This suggests that over this period of time, self-reflection continued to develop for participants who attended the MPG-BPD program, and it appears that this is associated with increased awareness.

> *Much more of an awareness about the issues I have, and the triggers…The group was a catalyst maybe for allowing me to continue to go deeper…the course made me reflect on my values…and I started to do a few things to align with my values (Fiona).*

> *I'm more aware of how the two work together – dealing with my issues, and separating it from what the kids are going through – that we're both individuals, and they have their issues as well. And trying not to make my problem their problem…not entangling. I think with the mindfulness, it's a huge thing. It stops me, to think – break it down. Primary emotion, secondary emotion; primary issue, secondary issue…"whose feelings am I dealing with, mine or the child's?" (Aisyah)*

I wouldn't notice that if I was sick in bed that maybe it was just too much, whereas I was sick in bed and I thought well look at all the stuff that's happened and I thought there must be something in that. I'm not very good at paying attention to my body and my thoughts still but I'm better than I was. I do try to attribute things to other things now, whereas before I'd just go "I'm sick" or "I'm just angry today". Now I'm looking for answers (Alena).

Reflection on internal mental states.

Child.

Five participants (Kate, Fiona, Aisyah, Kylie, Daria) overtly expressed increased reflection on their children's internal mental states post-program, and this was described by an additional two participants six months later (n = 6). This indicates that this reflectiveness continued to develop over the six months following the MPG-BPD program. This is supported by the significant increase in levels of interest and curiosity in child's mental states, as measured by the PRFQ, from post-program to six-moth follow-up.

It's more of just trying to think about things from their perspective a bit more and think of what they actually need and that sort of – just awareness I guess. I might not always be great at meeting those goals but at least I have some awareness now, or – thought to have an awareness, rather than just being oblivious (Kate).

Just seeing what their needs are. Looking at it from their point of view. "What do they need from me?" (Fiona)

I would say the biggest thing that I notice is me trying to talk to her more and ask her more questions and try to get her to tell me how she feels…I'm still not getting that much, but I'm trying harder to just get her to talk about how she feels about certain things because I think she's quite good at masking, she's a bit like her mum in some ways…Just trying to understand her better (Alena).

Others.

For some participants (n = 3), this ability to reflect on internal mental states seems to have expanded to other people in their lives, as they described a consideration of the perspective of others six-months after the program.

> *Give people a chance, give myself a chance, just try and see things from their point of view (Fiona).*

> *Just keeping an open mind that people might have their own things happening in life, and they may not notice me walking by (Alena).*

8.3.4.2 Changes in self-concept.

Table 10 identifies the main changes in self-concept, which have been organised into major themes and subthemes. The major theme was improved self-concept.

Improved self-concept.

The six participants who completed the six-month follow-up interviews described improved self-evaluations, with five of those participants having reported this at post-program. This indicates that the MPG-BPD program results in an improved self-concept that is maintained and further developed over the following six months.

Table 10

Changes in self-concept

Theme	Sub-theme	N
Improved self-concept		6
	View of self as good enough mother	6 (Kate, Fiona, Aisyah, Jessica, Alena, Kylie)
	Reduced self-criticism	5 (Kate, Fiona, Jessica, Alena, Kylie)
	Increased self-efficacy	3 (Fiona, Aisyah, Jessica)

View of self as good enough mother.

Four participants (Fiona, Aisyah, Jessica, Daria) considered themselves to be good enough mothers post-program. At six-month follow-up all participants (n = 6) identified with the good enough mother. This suggests that the perception of self as a good enough mother can strengthen over time and it appears to be associated with participants' reflecting on the concept, becoming less judgemental of self, and actively repairing with their children.

> *What really stuck was the ideal mother and the good enough mother…most days it goes through my head at least once or twice that it, it wasn't a concept that I'd thought of before the group because it wasn't something that I've really thought about. When we went through it in the group and I thought about it once I got home and it was, well, they really are in my head intertwined and tucked together and the more I try and work with that, the lesser, the further apart they become and the good enough mother doesn't have to be the perfect mother (Kylie).*

You do the best you can, and I'm probably doing the best I can….I'm just reminding myself constantly now to be – not as judgmental, that I do the best I can. Someone else could do better than me, but I'm not that someone else. So just being mindful of those things (Aisyah).

So I feel like most of the time I'm close enough to that good enough, you know…it's so completely not perfect mother or textbook mother, but good enough mother (Jessica).

I'm good enough most of the time. I do fall below that and I do go above that. When I go below I do the restorative and the repair work (Fiona).

Reduced self-criticism.

All participants (n = 7) reported a reduction in self-criticism at post-program and/or at six-month follow-up. Three participants reported this at both time points (Kate, Jessica, Kylie). Two participants (Fiona, Alena) reported this only at six-month follow-up. Two participants (Aisyah, Daria) only reported this post-program, with Daria not undertaking the follow-up interview.

I can see the good in me and I can see the good in other people now because I see the good in me…I'm much more easy on myself (Fiona).

I'm a bit less harsh on myself...I would've beaten myself up for weeks on end going "what did I do wrong, what was the situation, why has this happened?" (Jessica)

I'm not so critical of myself and I'm able to enjoy my time with (son) more because I'm stressing about "am I being the ideal mother?" (Kylie)

I think I give myself credit where it's due, more than I did before (Alena).

Increased self-efficacy.

Three participants described experiencing increased self-efficacy post-program (Kate, Jessica, Kylie), with Jessica reporting this again six-months later. Increased self-efficacy was implied by Aisyah and Fiona's descriptions of increased confidence at six-month follow-up.

> *I probably have more belief in myself, more confidence in myself. I can do this (Aisyah).*

> *Confidence from dealing with life situations, and facing things and deciding I was going to take a stand (Fiona).*

8.3.4.3 Changes in self-compassion.

Table 11 identifies the main changes in self-compassion, which have been organised into major themes and subthemes. The major theme was increased self-compassion.

Increased self-compassion.

Three participants (Fiona, Aisyah, Alena) reported increased self-compassion post-program, and this was depicted by all interviewed participants six months later (n = 6). While self-compassion was found at post-program to be a subcomponent of the theme of self-care, it emerged as a strong theme in the six-month follow-up interviews. This indicates that over this time period, self-compassion was maintained and continued to develop for participants who attended the MPG-BPD program.

Table 11

Changes in self-compassion

Theme	Sub-theme	N
Increased self-compassion		6
	Self-care	5 (Kate, Fiona, Aisyah, Jessica, Alena)
	Self-nurturing	4 (Kate, Fiona, Jessica, Alena)
	Kindness to self	2 (Fiona, Kylie)

Self-care.

The five participants who reported increased self-care post-program, also described this six months later, which suggests that increased self-care is an outcome of the MPG-BPD program that is maintained over time. Although Kylie did not report this in her interviews, it is possible that this may have applied to her without being expressed.

> *The amount of times now when I'm at home and I go into the bedroom and just sit on the bed quietly and do nothing. And literally just stop. I don't think I ever did that. I'd never just sit on the bed and take some time out and understand that I was just sitting there and being calm and quiet and really noticing cause it's not something I'd ever do, that I'm being very calm and quiet (Alena).*

> *Finding time for myself, that's a huge challenge, because I feel like they [children] over-dominate my life…I've recognized that it's also partially my doing, because I was so focused on the house. But...it's my turn now…I think from the group I realised that we were so dedicated to our kids that we forgot about ourselves. And I saw that in the two mothers, and I thought "well hang on I'm doing the same thing – and forgetting about myself" (Aisyah).*

Self-nurturing.

Of the five participants who reported increased self-nurturing post-program (Kate, Fiona, Aisyah, Jessica, Alena), four of these described self-nurturing six months later (Kate, Fiona, Jessica, Alena). The following quotes illustrate how participants used self-nurturing when experiencing distress.

> *I usually try to take a course of action that will take me away from the negative spiral. So you know, try to make myself go and visit someone even though I don't want to go out of the house, and stuff like that (Kate).*

> *I self-nurtured, and I removed myself away from the situation and I took some time out, and I did something physical and I recognized what was irking me and why it was irking me (Fiona).*

> *The most effective way I've used it is to stop and stand still. I will just stand still in there and not panic. I was panicking and I just stopped and took everything really slowly (Alena).*

Kindness to self.

Two participants had developed an attitude of kindness towards themselves six-month after the program. This suggests that it may take time to develop a stance of being kind to oneself following the MPG-BPD program.

> *The basic things to provide for a child that I had to – I felt that weren't necessarily provided for me. Sort of gave me – helped me become more understanding of myself and more forgiving of my faults, I suppose, in parenting (Fiona).*

> *I'm more open and I'm more compassionate because I'm trying to be more in touch with myself and what's going on around me (Kylie).*

8.3.4.4 Changes in acceptance and emotion management.

Table 12 identifies the main changes in acceptance and emotion management, which have been organised into major themes and subthemes. Major themes included: increased acceptance and improved emotion management.

Increased acceptance.

An additional three participants portrayed increased acceptance at six-month follow-up (n = 6) than at post-program (n = 3, Fiona, Aisyah, Alena). This indicates that acceptance is an outcome of the program that is maintained and continues to develop over time.

Table 12

Changes in acceptance and emotion management

Theme	Sub-theme	N
Increased acceptance		6 (Kate, Fiona, Aisyah, Jessica, Alena, Kylie)
Improved emotion management		6
	Emotion awareness and identification	6 (Kate, Fiona, Aisyah, Jessica, Alena, Kylie)
	Reduced reactivity	6 (Kate, Fiona, Aisyah, Jessica, Alena, Kylie)
	Improved emotion regulation	6 (Kate, Fiona, Aisyah, Jessica, Alena, Kylie)

Acceptance seems to result from increased mindfulness, self-compassion and emotion management. For Fiona, self-acceptance stemmed from "realising that I am a good enough person".

> *I'm more accepting of myself, and I'm not as – hard on myself (Fiona).*

> *Accepting that the situation is what it is, not necessarily accepting the belief of it, but accepting that it is what it is, but I'll deal with it later (Aisyah).*

> *Accepting that I am doing the best that I can, and that's it (Aisyah).*

> *I try to accept that I'm doing the best that I can with what I've got (Kylie).*

> *I still have the negative thoughts but now I will tell myself often, and I'll have a giggle in the car, it came from the course, "oh you're having those thoughts again". I use some of those tips and I can actually get a bit of a giggle out of that (Alena).*

Improved emotion management.

The six participants who described improved emotion management post-program, also reported this at the six-month follow-up, which indicates that emotion management skills result from the MPG-BPD program and are maintained over time. At six-month follow-up improved emotion management encompassed three thematic categories: Emotion awareness and identification, reduced reactivity, and improved emotion regulation.

Emotion awareness and identification.

Those six participants reported an increased awareness of emotions and this appears to have resulted in improved emotion identification abilities. Fiona and Kylie illustrated how mindfulness resulted in emotion identification and improved emotion management.

> *Mindfulness certainly helped. And because it allows you to name those feelings you are feeling and to try and distance yourself from them, but to observe them and not judge them, and to actually be okay with feeling like that (Fiona).*

> *If I remember I'll do it before, when I get angry, before I snap, before I actually open my mouth and say anything. I'll try and bring it all into perspective and label what I'm feeling and why (Kylie).*

For Alena, this also resulted in improved self-care:

> *Just not taking as much on, and seeing the difference between feeling calm and feeling really overwhelmed, and it took me awhile to realise that I just couldn't take anymore. I had never noticed that before (Alena).*

Reduced reactivity.

Reduced reactivity was also described by all six participants at six-month follow-up, with those six also having reported this post-program. This suggests that reduced reactivity to mood and emotions is an outcome of the MPG-BPD program and is maintained over time. This result is supported by the significant decrease in emotional reactivity, as measured by the Emotional Reactivity subscale of the DSI, between pre-program and six-month follow-up.

Usually because I pay attention to an emotion or a feeling, that alerts me to something going on inside. And I try to figure out where it's coming from, and I decide then how I'm going to react, as opposed to just barging in (Fiona).

I'm not so quick to anger. I try and sort of rationalise and think through before I act (Kylie).

I think I'm more aware of the kids; and more times now I can catch myself and be calmer in my approach with them. I don't fly off the handle like I did, every time (Kate).

I don't get the physical reactions I used to get when I would think of negative things. Or if I do I can quite quickly, not push them away, but just go "that's just the way it is" with certain things. I could never; I would just go with it. I'm always happy with myself when I can do that. And I know; I feel it when I've done that. It's something I couldn't do before. I wouldn't be able to tear myself away from a certain thought or feeling; I'd just linger on it for whatever amount of time. I can just take that breath and go yeah, more than before (Alena).

I've no longer been retreating into that fog that the drugs gave me. I have to deal with things as they are and things are a bit more clear, and if things are upsetting me I won't let it all sort of float away, I have to deal with it because that's important if I wanna stay sober. If I don't want to relapse into drugs I have to make sure that I'm dealing with things as best as I can (Jessica).

Improved emotion regulation.

All six participants described improved emotion regulation abilities six months after the program, indicating that improved emotion regulation is a result of the MPG-BPD program that is maintained over time. This outcome is supported by the significant decrease in emotion regulation difficulties, as measured by the DERS, from pre-program to post-program and from pre-program to six-month follow-up.

I'm more able to regulate my emotions, and I do the – press the pause button (Fiona).

I try and separate myself from them [difficult emotions]. In that, yes they're there but they don't have to consume me (Kylie).

I do still get upset about things...I still have my little immediate explosions but I feel like I don't carry them around for weeks now. It's like "ok well that's happened, how am I going to address it?" It's a bit more of that… I'm still having days when I'm not happy with how I've reacted to something or whatever, but I think there are more days when I'm finding better solutions, than just getting really angry. And then when I do feel like I might have crossed the line I can bring myself back a lot quicker (Alena).

I handle it a lot better, but it comes back to just being more mindful. Just being more aware…of where it's taking me. I know what it's like to be down there, so I don't allow myself – I might allow myself one step down, two steps down – "oh it's getting dark there, let's get back up" (Aisyah).

In summary, the most frequently reported outcomes of the MPG-BPD program that were maintained at six-month follow up for all participants interviewed (n = 6) were increased reflective functioning, improved self-concept, increased self-compassion, increased acceptance, improved emotion management. It appears that these results applied to participants' lives in general as well as in their role as a mother, and that these program outcomes were maintained over time.

Chapter 9: Case Analysis Results

9.1 Case Study analytic procedure

To further test the hypotheses that the program created significant differences for participants in a range of outcomes, Friedman Tests were performed on the individual participants' scores on the quantitative measures across the three time points (pre- post-program, and six-month follow-up) to identify significant main effects. As this is an exploratory study with a small number of participants, Wilcoxon Signed Ranks Tests were conducted to investigate differences between time points even when Friedman Test results were not significant to track the process of change for each participant. For the two participants who did not complete the six-month follow-up measures (Kate and Daria), only Wilcoxon Signed Ranks Tests were able to be performed. The nonparametric tests examined the individual scale and subscale items to explore individual participant changes between pre- and post-program data, post- and follow-up data, and pre- and follow-up data. Case analysis using nonparametric statistics to examine change in scale item ratings is a method used to assess within-person change. This nonparametric approach has been recommended for the statistical analysis of single-case designs (Busk & Marascuilo, 1992; Marascuilo & Serlin, 1988). The case study quantitative findings have then been triangulated with participants' qualitative interview data in order to examine whether they converge and thus validate each other.

9.2 Kate

Kate was married with two sons aged 8 and 6 years. Her youngest child had a diagnosis of ADHD and Kate experienced difficulties dealing with his behaviour. On assessment using the SCID, she met criteria for BPD and Bipolar II Disorder. Prior to attending the MPG-BPD program Kate endorsed all nine criteria for BPD and reported the highest BPD symptom severity of all participants on both the PDQ-4+ (27 out of a possible 36) and the BEST (high severity, 54 out of a possible 72). Kate participated in the six-month follow-up interview but did not complete a questionnaire at that time.

BPD symptom severity.

As shown in Table 13, there was a significant reduction in Kate's BPD symptom severity ratings post-program, as measured by the PDQ-4+ and the total BEST ratings. Closer examination of the BEST subscales found a significant reduction in Kate's ratings of thoughts and feelings associated with BPD, with non-significant trends for negative behaviours to decrease and positive behaviours to increase from pre- to post-program.

Table 13

Kate: BPD Symptom Severity Scores and Wilcoxon Signed Ranks Tests

	Pre-program	Post-program	*z*	*n*
PDQ-4+				
BPD Symptoms	27	20	-2.33*	9
BEST	54	27	-3.35**	15
Thoughts and Feelings	33	15	-2.64**	8
Behaviours - Negative	15	8	-1.84	4
Behaviours - Positive	9	11	1.41	3

*p<.05

**p<.01

Note. n = number of scale and subscale items.

Although participants were not explicitly asked about their BPD symptomatology, the following quotes further illustrate the reduction in Kate's BPD symptom severity for three BPD criteria. Six months after the program, Kate identified changes that had occurred in her relationships:

> *I'm a bit more calm with that as well, and a bit less – I don't know… a bit less likely to chuck a bomb on a relationship that's annoying me. I'm more inclined to go "Okay we'll just ride that bit out".*

When asked to clarify how she would previously "chuck a bomb on a relationship", Kate elaborated:

> *I just walk away, I just cease contact altogether. That's it. Whereas now, I guess I just keep being there, I suppose. If I feel that for some reason the person's not really involved in the relationship or whatever, or if I feel like it's one-sided, or any of those sorts of…if I feel slighted, that sort of thing. Whereas I guess I'm trying to be more, now "Okay well they haven't contacted me, I'll contact them" – you know I'm trying to be more like that.*

This indicates that since the program, Kate had altered her interpersonal responses, and that the pattern of unstable and intense interpersonal relationships characteristic of BPD had decreased following the program and was maintained six months later, indicating reduced symptom severity.

> *Instead of completely panicking and then getting angry because I couldn't handle it, I sort of managed it. I felt absolutely like shit after, but – at least I didn't scream and call him a shit and all that.*

This indicates that following the program and six-months after the program, Kate's ability to control her anger had increased and her emotional reactivity had decreased, further demonstrating a reduction in her BPD symptom severity.

Mindfulness.

Significant increases from pre- to post-program were found for Kate's overall mindfulness, and the mindfulness facets of describing, acting with awareness, non-judging of inner experience, and non-reactivity to inner experience (see Table 14).

Table 14

Kate: Five Facet Mindfulness Questionnaire (FFMQ) Scores and Wilcoxon Signed Ranks Tests

	Pre-program	Post-program	*z*	*n*
FFMQ	77	105	4.53***	39
Observing	23	25	0.82	8
Describing	16	24	2.53*	8
Acting with Awareness	15	19	2.00*	8
Non-Judging of Inner Experience	10	16	2.45*	8
Non-Reactivity of Inner Experience	13	21	2.27*	7

*p<.05

***p<.001

Considering Kate's own report, she was actively applying mindfulness following the program:

> *With situations where I was upset, I would try to bring the idea of mindfulness to my mind, and I tried to do the chopping the vegetables and washing dishes thing and just everyday things every now and then. You know sniff a lemon, or do those things to try and heighten my awareness.*

Six months after the program, Kate was aware of her increased mindfulness, particularly regarding her thoughts and emotions:

> *I'm trying to be a bit more calm about a lot of things, I guess. And try to develop a bit of an awareness of thoughts of feelings and just – trying to hold onto the fact that I know they all pass, and all that sort of stuff. Try not to be weighed down too much.*

> *I'm more aware of my thoughts, and I'm more aware of when I'm having negative thoughts. What I actually do based on that isn't necessarily always the optimum choice, but… I'm not quite so blindly running around.*

Parental reflective functioning.

As shown in Table 15, following the program, Kate had a significant increase in mentalizing modes of thinking. Although there was a trend towards increased overall parental reflective functioning, there were no significant changes in interest and curiosity about her children's mental states, nor changes in certainty about mental states, that is, being less likely to think that she can be a mind reader. Thus, these quantitative measures give only a modest indication that Kate's capacity to be reflective improved.

Table 15

Kate: Parental Reflective Functioning Questionnaire (PRFQ) Scores and Wilcoxon Signed Ranks Tests

	Pre-program	Post-program	*z*	*n*
PRFQ	76	88	1.56	18
Mentalizing	24	32	2.06*	6
Lack of Certainty about Mental States	32	35	0.38	6
Interest and Curiosity about Mental States	20	21	0.58	6

*p<.05

Following the program, however, Kate identified an increased ability to consider the mental states of others:

> *It's not constantly me thinking about outcomes for me. And you're not focusing as much on your own stuff and not being happy or whatever, you sort of can recognise that for what it is, or see it and go "well okay that's me". You seem to allow a bit more room to see other people and think "how is this for them?"*

Six months later Kate indicated that her increased reflective functioning had been maintained and related to improved emotion regulation.

> *I guess the biggest thing has been a bit more calm – you know if I'm upset with them or – just the times that I fly off the handle, but I'm a lot more – generally – trying to be aware of my impact on them.*

> *[I'm] trying to think more about them. What's going on for them, how things will go for them depending on how I try and handle it.*

Emotion regulation.

There were significant reductions in Kate's overall emotion dysregulation, nonacceptance of negative emotions, difficulties in goal-directed behaviour, impulse control difficulties, and limited access to emotion regulation strategies, from pre- to post-program (see Table 16). Non-significant trends of reduced lack of emotional awareness, lack of emotional clarity, and emotional cutoff were also apparent.

Table 16

Kate: Emotion Regulation Scores and Wilcoxon Signed Ranks Tests

	Pre-program	Post-program	*z*	*n*
DERS	157	119	-4.92***	36
Nonacceptance of Emotion Responses	30	24	-2.45*	6
Difficulties in Goal-Directed Behaviour	25	20	-2.24*	5
Impulse Control Difficulties	25	17	-2.07*	6
Lack of Emotional Awareness	23	20	-1.34	6
Limited Access to Emotion Regulation Strategies	34	25	-2.46*	8
Lack of Emotional Clarity	20	13	-1.89	5
DSI				
Emotional Reactivity	61	60	-0.45	11
Emotional Cutoff	56	52	-1.27	12

*p<.05

***p<.001

Following the program Kate reported that she was more aware of, and not as reactive to moods, resulting in increased self-care.

> *Before I'd get drawn in a little bit more with the whole thing…and you know wherever that was taking me or whatever I would allow that to happen. Whereas now I'm a bit more recognising it and able to do things to keep going to – that I know would help to make me well or, you know help to try and shift that mood.*

Six months after the program, Kate was aware that her experience of being a mother had improved, and associated this with increased emotion regulation.

> *I guess having more of that calm, trying to be calm. I've noticed more that makes the kids a bit easier as well. So that's a bit easier, and also trying to give them a little bit of time here and there, makes them easier for me to manage as well.*

Parenting stress.

As shown in Table 17, there were non-significant trends of reduced parenting stress, lack of parenting competence, social isolation, and attachment dysfunction from pre- to post-program. There was a trend for role restriction to increase from pre- to post-program, contrary to prediction.

Table 17

Kate: Parenting Stress Index (PSI) Scores and Wilcoxon Signed Ranks Tests

	Pre-program	Post-program	*z*	*n*
PSI	119	115	-0.42	33
Lack of Competence	52	49	-1.34	13
Isolation	19	17	-0.82	6
Attachment Dysfunction	25	24	-1.13	7
Role Restriction	23	25	1.00	7

Kate reported that her tendency to avoid her children had lessened following the program, and she explained how this had impacted on her parenting self-efficacy:

> *I'm not avoiding them as much as I was before either…That makes me feel better about myself as a mum. You don't feel great about yourself when you know you're avoiding the kids.*

Six months later Kate described an increased awareness of positive changes in her parenting as well as an increased acceptance of her parenting abilities.

> *Sometimes I feel like I'm doing more good enough mum stuff, and some things I've been able to accept more.*

Depression, anxiety and stress.

As demonstrated in Table 18, Kate had a significant reduction in her total DASS score and in depression following the program. While there was a non-significant trend of reduced stress from pre- to post-program, contrary to prediction her anxiety slightly increased post-program. Relative to Australian norms (see method), Kate's level of depression and stress decreased from moderate to normal, while her anxiety was in the normal range pre- and post-program.

Table 18

Kate: Depression, Anxiety and Stress Scale (DASS) Scores and Wilcoxon Signed Ranks Tests

	Pre-program	Post-program	*z*	*n*
DASS	41	22	-2.97**	21
Depression	20	4	-2.27*	7
Anxiety	1	4	1.00	7
Stress	20	14	-1.73	7

*p<.05
**p<.01

Six months after the program, Kate reported a reduced frequency of severe low mood and improved management of depressive symptoms:

> *I think that I'm more able to not have as many big lows related to lots of thoughts.*

> *If I'm just having a few thoughts that are quite negative – I'm more able to see that it's happening, and take some steps to go and do this or go and see a friend or do something to put the brakes on or… you know change the way I'm thinking, or just put me in a different space I guess.*

Attachment orientation.

As shown in Table 19, little change was apparent in Kate's attachment orientation although there was a non-significant trend of increased avoidance.

Table 19

Kate: Experiences in Close Relationship Scale Short Form (ECR-S) Scores and Wilcoxon Signed Ranks Tests

	Pre-program	Post-program	*z*	*n*
ECR-S				
Anxiety	34	33	-1.00	6
Avoidance	22	26	1.41	6

Kate selected two general relationship styles that best described her in close relationships pre-program, as assessed by the RQ: fearful and preoccupied. At post-program, Kate only selected the fearful attachment style. Figure 1 shows that Kate rated fearful and preoccupied attachment styles the highest at pre-program, while the secure attachment style was rated the lowest. At post-program the fearful attachment style had increased slightly and the dismissing attachment style had the greatest increase, while the secure attachment style rating had increased slightly and maintained the lowest rating. These changes are consistent with the trend of increased attachment avoidance in the ECR-S.

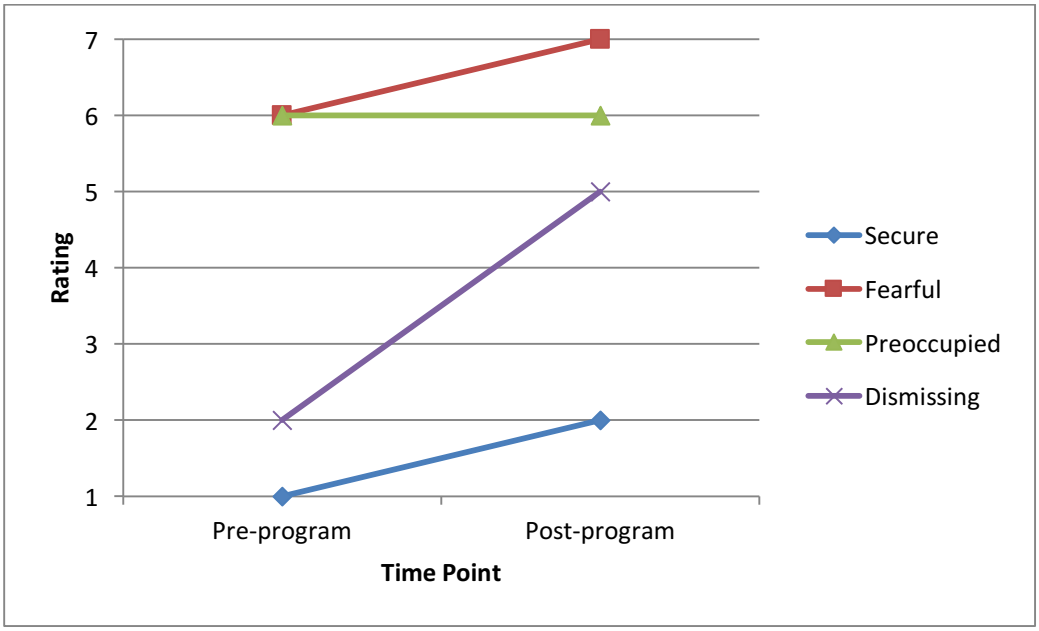

Figure 1. Kate: Attachment style ratings.

Prior to the program, Kate was aware of a similar tendency in parenting as her mother, and also identified a behavioural inconsistency, at times pulling away from her children and other times pulling them close; consistent with a preoccupied and fearful attachment style.

> *I probably try to ignore the kids as much as she did. But she wasn't nasty or aggressive or any of those sorts of things. But on the other hand, I'm aware that I'm like that, try to do cuddles and kisses and say "I love you" as well.*

Although the prominent attachment styles did not change significantly following the program, Kate reported changes in attachment behaviours towards her children:

> *I'm a bit more, sort of hugs and cuddle time. And a few more times I've taken them out to play or do stuff like that or – taking them to a friend's where they've got kids. I'm sort of taking them with me rather than escaping.*

I'd say I spend more time with them. I've been more aware of the time that I spend out of the house. I used to spend quite a bit of time out of the house…I'm not avoiding them as much as I was before either.

Six months later these attachment behaviour changes were maintained and were continuing to develop, with an associated reduction in attachment anxiety and avoidance.

I still have a resistance to spending time with them, but I'm more able to push myself to do that, and…a number of times out of those times that I do that, I'll find myself enjoying doing stuff together or being playful with them or something like that…just a bit more relaxed, and even sometimes when they've been in trouble and I've tried to be more – the humour approach, sort of discipline but that step before you really have to say "right that's enough". Trying to keep it a bit lighter...and to not get myself that worked up as well. So I think we've got a bit easier relationship. And I do talk to them a bit more, not just general talking...I don't find their interactions as painful as I did.

9.3 Fiona

Fiona was married with three daughters aged 14, 11 and 7 years. Her second child had experienced inappropriate sexualised behaviour from another child and was receiving counselling through the South Eastern Centre Against Sexual Assault. Fiona tended to identify with this daughter and considered both herself and her daughter to be victims. On assessment using the SCID, she met subthreshold levels of BPD as she endorsed 4 of 9 BPD criteria. Prior to attending the MPG-BPD program Fiona reported low to mid-range BPD symptom severity relative to the other participants on the PDQ-4+ (17 out of a possible 36) and the BEST (low to mid-range severity, 30 out of a possible 72).

BPD symptom severity.

As demonstrated in Table 20, there was a significant decrease, according to Friedman Tests, in Fiona's BPD symptom severity, as measured by the total BEST ratings, across the three time points, with a Wilcoxon Signed Ranks Test demonstrating a significant decrease from pre-program to post-program for Fiona's total BEST ratings (z = -2.65, p = .01). Her ratings of thoughts and feelings associated with BPD also significantly decreased from pre- to post-program (z = -2.24, p = .03). Fiona's PDQ-4+ BPD symptom severity ratings, while not significant, decreased from pre- to post-program, demonstrating a trend in the hypothesised direction over time.

Table 20

Fiona: BPD Symptom Severity Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 (df = 2)	n
PDQ-4+					
BPD Symptoms	17	10	11	3.44	9
BEST	30	23	24	6.06*	16
Thoughts and Feelings	20	15	15	2.00	8
Behaviours - Negative	7	5	6	3.00	4
Behaviours - Positive	12	12	12	1.40	3

*p<.05

Despite not being directly asked about her BPD symptomatology, Fiona described reduced symptom severity for two BPD criteria six-months following the program:

> *There was a lot of rage and anger, and it seems to have subsided.*
>
> *Sadness and melancholy were the big things I was up against. Rage, anger, irritation, irritability, lack of patience...the rage and the anger have subsided, and that's just so nice.*

This indicates that since the program, Fiona experienced a noticeable reduction in affective instability and intense anger, characteristic of BPD, which had been maintained over time.

Mindfulness.

Significant increases were found in Fiona's overall mindfulness, and in the observing facet of mindfulness across the three time points as indicated by the significant Friedman Tests shown in Table 21. Closer examination using Wilcoxon Signed Ranks Tests revealed significant increases from pre- to post-program for Fiona's overall mindfulness ($z = 3.27$, $p = .001$) and the observing facet of mindfulness ($z = 2.45$, $p = .01$). As shown in Table 20, six months later these ratings decreased, yet remained above those at pre-program, with a significant increase in overall mindfulness demonstrated between pre-program and six-month follow-up ($z = 2.41$, $p = .02$). Overall, individual facets of mindfulness generally showed non-significant trends of increasing post-program, and although decreasing somewhat at the six-month follow-up, they remained above pre-program levels.

Table 21

Fiona: Five Facet Mindfulness Questionnaire (FFMQ) Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 ($df = 2$)	*n*
FFMQ	133	149	145	13.39**	39
Observing	29	35	33	7.18*	8
Describing	37	38	36	1.00	8
Acting with Awareness	25	27	30	3.13	8
Non-Judging of Inner Experience	24	26	26	1.33	8
Non-Reactivity to Inner Experience	18	23	20	5.14	7

*p<.05

**p<.01

Following the program Fiona described how she applied mindfulness for both positive and negative emotional states:

> *It's a great tool to have, and it's something that is very centring, and at times of stress is probably the times when I think about it most...But also joyful times, where you really do get a good day, or you just smell the roses. But I was on that path anyway, but it's just really reinforced – seeing the good, balancing up a bit, definitely has brought the balance back.*

Fiona's increased mindfulness, and particularly the acting with awareness facet six months later, was demonstrated by her continued active practice and the awareness of her increased mindfulness skills:

> *I do a session once a month at the mindfulness centre...I go so I keep my skills up. And I put on tapes every now and then, but it's just part of my life now. I mightn't be sitting down for five or ten minutes like we used to do here, but I'm pressing the pause button a lot, and like even while we've been sitting here I might be looking at the trees and I might be using my – to calm myself.*

Parental reflective functioning.

As shown in Table 22, there were no significant changes in reflective functioning overall or the level of interest and curiosity in her children's mental states across the three time points. Overall, it seems that reflective functioning did not significantly improve, although there were some inconsistent oscillations suggesting that, immediately post-program, Fiona was less likely to assume she could read others' minds, while at this same time point she showed a trend of decreased mentalizing.

Table 22

Fiona: Parental Reflective Functioning Questionnaire (PRFQ) Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 ($df = 2$)	*n*
PRFQ	99	100	96	0.04	18
Mentalizing	37	32	36	5.33	6
Lack of Certainty about Mental States	24	29	20	5.20	6
Interest and Curiosity about Mental States	38	39	40	1.20	6

In the following post-program quote, however, Fiona demonstrates changes in more general reflective functioning, something that the specific reflective functioning scale that focused more on awareness of the child's mental states, did not fully assess. Here, Fiona shows awareness of her own mental states and reflects on her own behaviours and how they affect her children.

Particularly if you haven't had the parenting as a child yourself, you're really open to repeating the cycle of – it's just programmed in you and no matter how intelligent, insightful – awareness changes that, and that's what mindfulness does. Once you're aware...You have to say to yourself "God I'm contributing to this" - it's very scary. I'm perpetuating this. I'm causing – I'm doing exactly to my kids, they're having exactly the same feelings that I got from my father. Because I'm deciding to behave like this.

Emotion regulation.

As shown in Table 23, significant reductions were found across the three time points for Fiona's overall emotion dysregulation, nonacceptance of negative emotions, and lack of emotional clarity. Closer examination using Wilcoxon Signed Ranks Tests revealed significant reductions for overall emotion dysregulation from pre- to post-program (z = -2.60, p = .009) and between pre-program and six-month follow-up (z = -3.89, p = .00); and for nonacceptance of negative emotions from pre- to post-program (z = -2.33, p = .02) and between pre-program and six-month follow-up (z = -2.23, p = .03). A significant decrease for lack of emotional clarity was found between pre-program and six-month follow-up (z = -2.00, p = .046). While a general trend was shown of reduction in emotional dysregulation on most other subscales from pre- to post-program, which were maintained at the six-month follow-up, these were not significant.

Table 23

Fiona: Emotion Regulation Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 ($df = 2$)	*n*
DERS	90	70	60	22.52***	36
Nonacceptance of Emotion Responses	23	12	10	11.20**	6
Difficulties in Goal-Directed Behaviour	16	11	10	5.20	5
Impulse Control Difficulties	15	14	13	0.67	6
Lack of Emotional Awareness	10	9	7	3.50	6
Limited Access to Emotion Regulation Strategies	17	16	15	0.62	8
Lack of Emotional Clarity	9	8	5	6.50*	5
DSI					
Emotional Reactivity	59	53	53	3.63	11
Emotional Cutoff	24	24	26	0.06	12

*p<.05

**p<.01

***p<.001

Six months after the program Fiona found that her experience of being a mother had improved, and this appears to be related to improved emotion regulation abilities that had developed over time. Consistent with her quantitative profile, Fiona demonstrated an increased awareness and acceptance of negative emotions alongside reduced emotional reactivity, which allowed her to reflect on internal experiences and make mindful decisions.

> *It's usually because I pay attention to an emotion or a feeling, that alerts me to something going on inside. And I try to figure out where it's coming from, and I decide then how I'm going to react, as opposed to just barging in.*

Fiona also reported a reduction in the negative emotional states she had experienced as a mother since her access to emotion regulation strategies had improved:

I'm not so scared and so overwhelmed and so fearful.

Parenting stress.

As shown in Table 24 significant differences were found across the three time points for Fiona's parenting stress, lack of parenting competence, and role restriction. There was a non-significant trend for overall parenting stress and lack of parenting competence to first decrease post-program, but this was not maintained as they then increased at the six-month follow-up ($z = 3.19$, $p = .001$; $z = 2.46$, $p = .01$ respectively), although they did not increase beyond pre-program levels. A similar pattern ensued for role restriction in that Wilcoxon Signed Ranks Tests revealed a significant reduction in role restriction from pre- to post-program ($z = -2.24$, $p = .03$), then there was a non-significant trend to increased role restriction noted at the six-month follow-up. Overall, while there seemed to be initial reductions in parenting stress post-program, these gains were not sustained at the six-month follow-up.

Table 24

Fiona: Parenting Stress Index (PSI) Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 ($df = 2$)	*n*
PSI	114	91	108	10.29**	33
Lack of Competence	52	36	46	8.19*	13
Isolation	15	17	16	2.47	6
Attachment Dysfunction	18	14	20	2.95	7
Role Restriction	29	24	26	6.13*	7

*p<.05

**p<.01

Immediately post-program, Fiona did identify an awareness that she was "more confident" in how she parented. Possibly, she still felt this improved sense of parenting self-efficacy six months after the program when she observed:

> *Recognising that they have two parents that love them and they have a roof over their head, and we're doing our best to the best of our ability.*

This suggests that for Fiona, increased parenting self-efficacy may be related to the concept of the 'good enough mother' and acceptance of self as a parent.

Depression, anxiety and stress.

As shown in Table 25, there was a significant change in Fiona's total DASS score across the three time points, and a Wilcoxon Signed Ranks Test found a significant decrease from pre- to post-program (z = -2.53, p = .01) and a significant increase six months later (z = 2.24, p = .03), although the total did not excess pre-program levels. Changes on subscales were not significant although they tended to mirror this general pattern. Relative to Australian norms, Fiona's level of depression decreased from mild at pre-program to normal at post-program and remained in this range at six-month follow-up, while her anxiety and stress scores were in the normal range at all three time points.

Table 25

Fiona: Depression, Anxiety and Stress Scale (DASS) Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 (df = 2)	n
DASS	30	14	24	9.92**	21
Depression	12	4	8	5.00	7
Anxiety	4	2	2	2.00	7
Stress	14	8	14	4.50	7

**p<.01

Fiona indicated that although she continued to experience lowered moods, her baseline mood had improved since the program and she was experiencing more positive emotional states than previously.

> *The dark days are definitely still there. That's, I guess, how to put it in a nutshell. But I'm probably up a bit more in the good days. We talked about that line underneath – well maybe I'm not normal, but I'm getting, I've raised – I'm a little bit more joyful...I definitely think it's [baseline mood] a bit higher.*

Attachment orientation.

As shown in Table 26, contrary to prediction there was a non-significant trend for Fiona to increase in attachment anxiety from pre- to post-program, and slightly decrease at the six-month follow-up. There was little change in her attachment avoidance.

Table 26

Fiona: Experiences in Close Relationship Scale Short Form (ECR-S) Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 ($df = 2$)	*n*
ECR-S					
Anxiety	26	29	28	1.53	6
Avoidance	8	9	8	0.67	6

Fiona selected the general relationship styles that best described her in close relationships as assessed by the RQ. She selected the preoccupied attachment style at pre-program, secure at post-program, and preoccupied six months later. However, this was not consistent with her ratings on the RQ, where she consistently rated the preoccupied attachment style the highest at all three time points as shown in Figure 2.

However, it did seem that she felt her behaviour was more in keeping with the secure attachment style post-program since her ratings of the secure style increased the most following the program. Yet Fiona was not able to sustain this sense of security in her interpersonal functioning her ratings decreased substantially six months later.

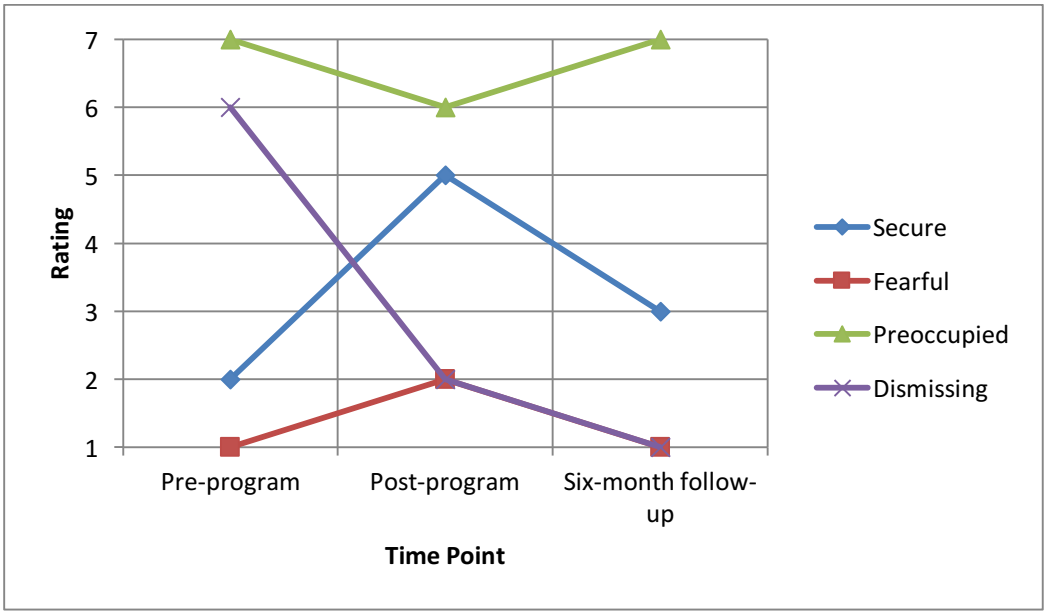

Figure 2. Fiona: Attachment style ratings.

Fiona described a change in her style of relating to her children immediately following the program, indicating a reduction in her preoccupied attachment style post-program:

> *I'm happier, more boundaries since I know, I suppose. But I try to do one-on-one time, try to check in with them individually, and really think about them as separate to me as well, even though with the middle child it's – you know I don't – she's not me, but she's very like me. But I separate myself.*

Fiona also described her reflection on her experience of being parented and how she has been able to develop an improved understanding and acceptance of this, as well as identify and accept responsibility for her own past behaviours.

I've been able to go back to my childhood as a result of the course and redefine – you know I could never do forgiveness. I gained understanding and acceptance, but now I've had to face up – and this is quite a difficult thing to say – that I was part of the problem.

9.4 Aisyah

Aisyah was married with two daughters aged 10 and 8 years. Aisyah had a previous diagnosis of BPD and had previously attended a Dialectical Behaviour Therapy course. On assessment using the SCID, she met criteria for Panic Disorder with Agoraphobia and Specific Phobia (animal type). Prior to attending the MPG-BPD program she met subthreshold levels of BPD, as she endorsed 4 of 9 BPD criteria, and reported the lowest BPD symptom severity of all participants on the PDQ-4+ (14 out of a possible 36) and the BEST (low severity).

BPD symptom severity.

As shown in Table 27, there were no significant changes in Aisyah's BPD symptom severity, although there were slight trends in the hypothesised direction of reduced BPD symptom severity from pre- to post-program to six-month follow-up, as measured by the PDQ-4+ and total BEST ratings. Her initial low symptom levels however, have made it less likely that significant changes might be demonstrated.

Table 27

Aisyah: BPD Symptom Severity Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 ($df = 2$)	*n*
PDQ-4+					
BPD Symptoms	14	13	11	1.18	9
BEST	17	16	15	1.00	16
Thoughts and Feelings	9	8	10	2.00	8
Behaviours - Negative	5	6	4	3.00	4
Behaviours - Positive	12	13	15	1.40	3

Aisyah herself however, recognised that prior to the program her mood reactivity had resumed, and six months after the MPG-BPD program she noticed that this affective instability had decreased.

> *I've lessened the pendulum…After my BPD, DBT [Dialectical Behaviour Therapy] course, everything was fine but then I started doing that thing again – the extremes, dealing with the stresses, but I've learned to bring it down, back to just a small swing rather than those big extremes. I mean a lot of that comes through the being aware.*

Clearly, as Aisyah indicates that the reduction in her affective instability is associated with increased mindfulness, and that symptom severity had decreased for this BPD criterion following the program. Considering Aisyah had previously completed a DBT program, her BPD symptom severity was relatively low prior to the MPG-BPD program and therefore this floor effect meant that significant decreases were less likely to occur.

Mindfulness.

As demonstrated in Table 28, there were significant increases in Aisyah's overall mindfulness, and in the mindfulness facets of acting with awareness and non-judging of inner experience across the three time points. Wilcoxon Signed Ranks Tests revealed significant increases between pre-program and six-month follow-up for overall mindfulness ($z = 2.86$, $p = .004$), acting with awareness ($z = 2.00$, $p = .046$), and non-judging of inner experience ($z = 2.12$, $p = .03$), whereas there were no significant changes immediately following the program, only a trend for overall mindfulness to increase. It is notable that significant increases occurred from post-program and six-month follow-up for Aisyah's overall mindfulness ($z = 2.04$, $p = .04$), acting with awareness ($z = 2.24$, $p = .03$), and non-judging of inner experience ($z = 2.12$, $p = .03$).

Table 28

Aisyah: Five Facet Mindfulness Questionnaire (FFMQ) Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 ($df = 2$)	*n*
FFMQ	139	143	152	9.07*	39
Observing	28	31	30	4.67	8
Describing	32	32	32	0.35	8
Acting with Awareness	27	26	31	7.00*	8
Non-Judging of Inner Experience	28	28	34	10.00**	8
Non-Reactivity to Inner Experience	24	26	25	0.80	7

*p<.05

**p<.01

Following the program Aisyah demonstrated a growing understanding and awareness of mindfulness. Considering her quantitative profile, this appears to have resulted in an on-going development of mindfulness skills.

> *I think it [MPG-BPD program] has prompted me to be more mindful, and I think I'm more mindful of being mindful. Whereas, in the past, I might have been mindful about something but you wouldn't be fully aware of it.*

> *I think making the mindfulness a routine, so much so that it's an automatic response to – it's a combination of being mindful of the situation, and then using the skills or questions like "fact or opinion?"*

> *Once you're mindful of yourself you then can handle - it's easier for you to be open to others because you're not trying to sort out – or get confused, between your emotion or the other person's emotion.*

Parental reflective functioning.

As shown in Table 29, there were no significant changes in Aisyah's parental reflective functioning, however there was a non-significant trend of increased interest and curiosity in her children's mental states across the three time points. There was a non-significant trend for her lack of certainty about mental states to increase (being less likely to think she can be a mind reader) from pre- to post-program, although this was not maintained at the six-month follow-up. There were non-significant trends contrary to prediction of decreased overall parental reflective functioning and mentalizing from pre- to post-program, although these increased between post-program and six-month follow-up, with Aisyah's overall parental reflective functioning having increased from pre-program to six-month follow-up. Overall, it seems that reflective functioning did not significantly improve, although Aisyah developed a greater interest and curiosity about her children's mental states across the time points.

Table 29

Aisyah: Parental Reflective Functioning Questionnaire (PRFQ) Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 ($df = 2$)	*n*
PRFQ	87	85	93	2.42	18
Mentalizing	41	34	40	5.60	6
Lack of Certainty about Mental States	17	19	17	0.00	6
Interest and Curiosity about Mental States	29	32	36	4.00	6

When interviewed six months after the program Aisyah reported an increased ability to consider the mental states of her children:

> *There's a reason behind how they do things or why they do things, and how they feel, and it's respecting that and putting that into the equation.*

This is consistent with her quantitative profile, as Aisyah's overall parental reflective functioning increased between post-program and six-month follow-up. This indicates that for Aisyah, the MPG-BPD program may have been a catalyst for the development of reflective functioning over time.

Emotion regulation.

As shown in Table 30, there were significant differences across the three time points for Aisyah's overall emotion dysregulation, impulse control difficulties, lack of emotional awareness, and limited access to emotion regulation strategies. Wilcoxon Signed Ranks Tests revealed, opposite to predictions, a significant increase in Aisyah's overall emotion dysregulation following the program ($z = 2.07$, $p = .04$). However, there was a significant decrease between pre-program and six-month follow-up ($z = -2.07$, $p = .04$). Significant reductions were also found between pre-program and six-

month follow-up for impulse control difficulties (z = -2.00, p = .046), and lack of emotional awareness (z = -2.00, p = .046), and a decrease for limited access to emotion regulation strategies from post-program to six-month follow-up (z = -2.33, p = .02).

Table 30

Aisyah: Emotion Regulation Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 (df = 2)	n
DERS	61	70	52	16.54***	36
Nonacceptance of Emotion Responses	9	10	9	2.00	6
Difficulties in Goal-Directed Behaviour	11	11	11	0.13	5
Impulse Control Difficulties	11	12	7	7.00*	6
Lack of Emotional Awareness	11	11	7	8.00*	6
Limited Access to Emotion Regulation Strategies	13	17	10	7.71*	8
Lack of Emotional Clarity	6	9	8	2.80	5
DSI					
Emotional Reactivity	31	48	30	13.56**	11
Emotional Cutoff	32	37	30	4.61	12

*p<.05

**p<.01

***p<.001

Similarly, Aisyah's emotional reactivity changed across the three time points with Wilcoxon Signed Ranks Tests indicating, contrary to predictions, a significant increase in emotional reactivity following the program (z = 2.70, p = .01), which was followed by a significant decrease at the six-month follow-up (z = -2.57, p = .01), with levels slightly below those at pre-program. As most of Aisyah's scores indicate increased emotion regulation problems post-program, and a return to pre-program levels or below at the six-month follow-up, it appears the program was not immediately effective for Aisyah's emotion regulation difficulties. However, it is notable that

Aisyah's total DERS score was the lowest of all participants prior to the program, so it may be this initially low level of emotion regulation difficulties made it less likely to see improvements.

However, Aisyah reported an improved experience of being a mother six months after the program, which appears to be associated with improved emotion regulation between post-program and six-month follow-up. The following quote demonstrates a reduction in emotion dysregulation and emotional reactivity, and indicates that Aisyah's emotion regulation strategies had developed in the six months following the program.

> *I do it differently. I think where I used to just scream and explode...I now control it.*

Aisyah's increased emotion dysregulation directly following the program is likely related to the stress she was experiencing from her involvement in building a house at that time. Possibly, the MPG-BPD program had an impact on her emotion regulation abilities, as the majority of Aisyah's emotion dysregulation ratings had decreased at the six-month follow-up, and most were below pre-program levels.

Parenting stress.

Table 31 shows significant differences across the three time points for Aisyah's overall parenting stress. Wilcoxon Signed Ranks Tests revealed, contrary to predictions, a significant increase in parenting stress from pre- to post-program (z = 2.06, p = .04), and then a significant decrease between post-program and the six-month follow-up (z = -2.26, p = .02), with levels below that at pre-program. Overall, it seems that Aisyah' parenting stress increased post-program (likely related to the increased

stress of building the family home) and then decreased to below pre-program levels six-months later.

Table 31

Aisyah: Parenting Stress Index (PSI) Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 ($df = 2$)	*n*
PSI	87	91	79	6.95*	33
Lack of Competence	30	28	31	0.67	13
Isolation	18	21	13	5.16	6
Attachment Dysfunction	14	16	13	2.48	7
Role Restriction	25	26	22	2.92	7

*p<.05

Despite this quantitative increase in lack of parenting competence, six months after the program, Aisyah identified that sharing experiences with other mothers in the group led to a re-evaluation of her own parenting, which combined with an increased awareness of self-doubt, resulted in an increased sense of parenting self-efficacy.

> *When I was listening to the ladies, and how...Kate...was struggling with her son and Fiona what she had to go through, and sort of thinking well what am I whinging about, you know? Am I maybe not stepping up to the plate, and being a good parent? And that's all the self-doubt going through, and thinking "I'm really not that good", that sort of stuff. But then stopping and realising no hang on I've done this, and watching my work with (daughter) turn her around…and not giving up on her, I think basically said "you can do it".*

Depression, anxiety and stress.

As demonstrated in Table 32, there were significant differences across the three time points for Aisyah's total DASS score and level of anxiety. While there was a non-significant trend opposite to prediction for her total DASS to increase from pre- to post-program, a Wilcoxon Signed Ranks Test revealed a significant reduction in her total DASS from post-program to six-month follow-up (z = -2.67, p = .008) and between pre-program and six-month follow-up (z = -2.12, p = .03). Her anxiety significantly increased from pre- to post-program (z = 2.12, p = .03), and although anxiety returned to pre-program levels at the six-month follow-up, this was not found to be significant. However, depression demonstrated a non-significant trend in the hypothesised direction across the three time points. Although stress did not change from pre- to post-program, it decreased at six-month follow-up. Aisyah's scores for depression and stress were normal at all three time points relative to Australian norms. Her anxiety at pre-program was extremely low and in the normal range, with little possibility of marked improvement. This increased to severe at post-program (related to the stress of building the family home) and returned to normal six-months later.

Table 32

Aisyah: Depression, Anxiety and Stress Scale (DASS) Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 (df = 2)	n
DASS	22	34	10	9.50**	21
Depression	8	6	2	3.50	7
Anxiety	2	16	2	7.14*	7
Stress	12	12	6	3.60	7

*p<.05

**p<.01

Consistent with her quantitative profile, Aisyah indicated that her stress and anxiety had decreased six months after the program, and related this to mindfulness strategies and lessened rumination.

> *I actually deal with things better because I'm not wallowing in it. I'm getting my mind to focus on different things, and then that time out from whatever I'm stressed about – suddenly makes sense. Or I find a solution to it...That whole "put it on a leaf, send it down the stream – go with the flow, I'll deal with it later".*

It is likely that this reduction in stress and anxiety is also associated with the completion of building the new family home.

Attachment orientation.

There were no significant changes following the program for either Aisyah's anxious-insecure or avoidant-insecure attachment orientation. As shown in Table 33, her attachment anxiety slightly increased at post-program, then returned to pre-program levels at six-month follow-up. Aisyah's attachment avoidance did not change from pre- to post-program, although there was a non-significant trend of decreased avoidance at the six-month follow-up.

Table 33

Aisyah: Experiences in Close Relationship Scale Short Form (ECR-S) Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 ($df = 2$)	*n*
ECR-S					
Anxiety	25	27	25	2.33	6
Avoidance	16	16	9	4.35	6

Aisyah selected the general relationship styles that best described her in close relationships as assessed by the RQ. Consistent with the ECR-S avoidance ratings, she selected the dismissing attachment style at pre-program and post-program, and the secure attachment style six months later. Figure 3 shows that this is further supported by Aisyah rating the dismissing attachment style the highest before and after the program, with both the secure and dismissing attachment styles rated the highest six-months after the program. The secure attachment style had the greatest decrease following the program, however it also had the greatest increase six months later.

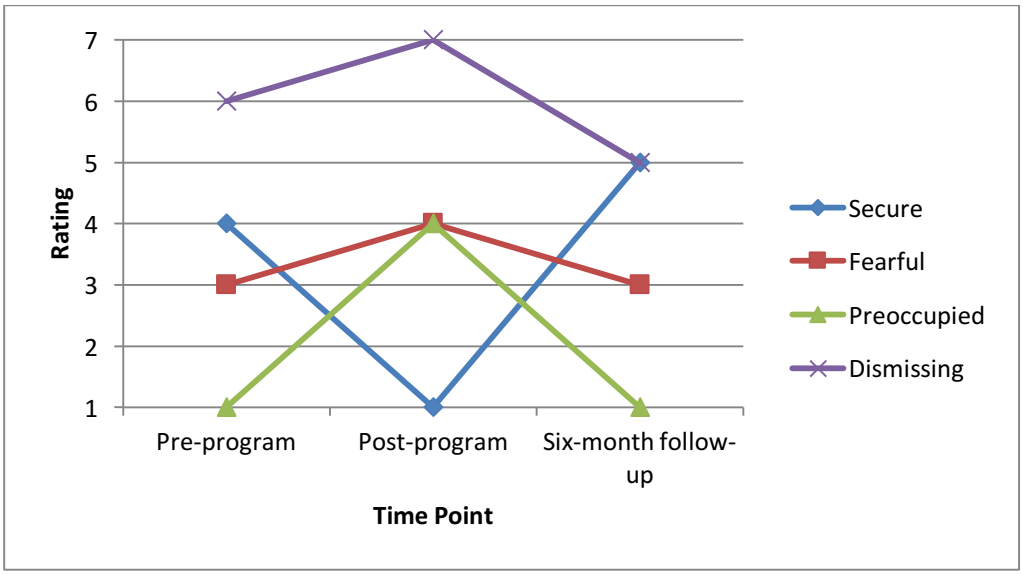

Figure 3. Aisyah: Attachment style ratings.

Following the program Aisyah indicated that her own mother behaved in a way that is consistent with the dismissing attachment style. It appears that by reflecting on her own experience of being parented, Aisyah identified her own children's needs and how she could meet these.

> *Realizing my difficulties with my mother, and then sitting down and breaking it down to all these needs, and yes my mum had a nanny for me that did this and that and that, but she wasn't there for that, and she wasn't there for that, and she wasn't there for that, and that's what I needed most. Out of all the things, those were the items I needed most. And these are the items that I need to be there for my girls.*

Six months later Aisyah illustrated how she and her husband had changed their parenting approach, which appears consistent with a reduced dismissing attachment style and an increased secure attachment style:

> *I think we're a bit more positive, in the sense that we're not taking a back seat. Probably in hoping for the best – we're more engaged, more involved.*

9.5 Jessica

Jessica was married with an infant son aged 1 year, and had recently reduced her substance use. On assessment using the SCID, she met criteria for Major Depressive Disorder, Recurrent, in full remission; and met subthreshold levels of BPD, as she endorsed 3 of 9 BPD criteria. Prior to attending the MPG-BPD program Jessica reported mid to high-range BPD symptom severity relative to the other participants, as she had the equal highest rating on the PDQ-4+ (27 out of a possible 36), and rated low to mid-range severity on the BEST.

BPD symptom severity.

As shown in Table 34, there were no significant changes in Jessica's BPD symptom severity across the three time points. Her profile on the PDQ-4+ indicates reduced BPD symptom severity from pre- to post-program and at six-month follow-up, demonstrating a non-significant trend in the hypothesised direction over time. In contrast, a Wilcoxon Signed Ranks Test indicated a significant increase in Jessica's total BEST score between pre- and post-program ($z = 2.17$, $p = .03$), with a non-significant trend of decreased BPD symptom severity six months later. Contrary to predictions, there were non-significant trends for Jessica's thoughts and feelings associated with BPD and negative behaviours associated with BPD to increase from pre- to post-program, and for positive behaviours to decrease. However, at the six-month follow-up, her negative behaviours had decreased below pre-program levels and her positive behaviours had increased above pre-program levels.

Table 34

Jessica: BPD Symptom Severity Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 ($df = 2$)	*n*
PDQ-4+					
BPD Symptoms	27	26	24	2.00	9
BEST	33	45	35	4.04	16
Thoughts and Feelings	20	25	25	0.21	8
Behaviours - Negative	10	14	9	3.71	4
Behaviours - Positive	12	9	14	5.64	3

Following the program Jessica noticed that her response to her family of origin had changed, with a reduction in her emotional reactivity and consequent impulsivity with substance use:

> *I was able to visit my family of origin interstate without having a relapse during that time. So that was kind of unique, and that was really good.*

Six months later Jessica demonstrated an awareness of how things were changing for her in relation to interpersonal conflict, as she noticed an increased ability to regulate her emotions, and consequently an improved ability to control anger and reduced reactivity of mood.

> *I do feel like I've dealt with things a bit better now, um, I think if I'd had that Facebook incident with the bullying I think I would've – I snapped several times. I was really upset about how this has happened, and I'm angry at myself for letting, for being upset over it, I feel like I should just be able to go 'uh, I don't care'...I think I handled it better than I think I would've a year ago or before the course. So I guess it has changed. Like, I wasn't not upset at all, I was upset. I think I just, yeah, was able to handle it from a different stand-point, not gonna let this person bring down my month, you know.*

Despite Jessica's quantitative profile not showing significant positive change at six-month follow-up, Jessica's own report at this time indicates that her BPD symptom severity had decreased for three BPD criteria: affective instability due to a marked reactivity of mood, impulsivity in a self-damaging area, and difficulty controlling anger.

Mindfulness.

As shown in Table 35, there were significant increases in Jessica's overall mindfulness, and in the mindfulness facets of describing and non-reactivity to inner experience across the three time points. Closer examination using Wilcoxon Signed Ranks Tests revealed significant increases from pre- to post-program for overall mindfulness ($z = 2.56$, $p = .01$), describing ($z = 2.46$, $p = .01$), and non-reactivity to inner experience ($z = 2.33$, $p = .02$). Six months later these were all above pre-program levels, with significant increases from pre-program for describing ($z = 2.53$, $p = .01$) and non-reactivity to inner experience ($z = 2.27$, $p = .02$).

Table 35

Jessica: Five Facet Mindfulness Questionnaire (FFMQ) Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 ($df = 2$)	*n*
FFMQ	94	109	105	10.17**	39
Observing	25	27	25	1.29	8
Describing	23	32	31	13.46**	8
Acting with Awareness	16	17	14	4.67	8
Non-Judging of Inner Experience	16	12	13	2.80	8
Non-Reactivity to Inner Experience	14	21	22	9.91**	7

**p<.01

Jessica identified that her increased mindfulness post-program related to the prominence of mindfulness during the MPG-BPD program:

> *I was already aware of the mindfulness technique, but I was able to, obviously we really focused on it over the group. So I find I'm able to use that fairly well now.*

Six months later Jessica's increased mindfulness appears to have been maintained, with the following quote demonstrating increased awareness and non-reactivity to inner experience:

> *Even though I haven't always been able to be 100% perfectly mindful, I have been able to keep in mind, these are emotions, they're no longer overwhelming me. Yes, I'm annoyed that I find myself stuck back on that loop but I'm aware that I'm stuck on a loop and I'm aware that it's not useful so I'm not gonna put that much mental energy into it or not devote as much mental energy to it.*

Parental reflective functioning.

As shown in Table 36, there was little change in Jessica's reflective functioning, with a non-significant trend to show that overall reflective functioning tended to decrease post-program, but returned to pre-program levels at the six-month follow-up. This pattern was strongest for interest and curiosity regarding her child's mental states, which showed a non-significant decrease immediately post-program, but returned to baseline levels at the six-month follow-up.

Table 36

Jessica: Parental Reflective Functioning Questionnaire (PRFQ) Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 ($df = 2$)	*n*
PRFQ	93	89	93	0.14	18
Mentalizing	37	38	38	0.00	6
Lack of Certainty about Mental States	19	18	18	1.00	6
Interest and Curiosity about Mental States	37	33	37	2.00	6

Despite Jessica's quantitative profile, the following post-program quote demonstrates some awareness and curiosity in the mental states that underlie her child's behaviour:

> *Sometimes (son) does something silly which makes us laugh, and then he realises he's making us laugh and then he does it more, so we laugh more and we just end up in hysterics because he's doing something crazy, and it's just so adorable. Because he obviously likes the attention, which to us is really funny because neither of us – we're both really shy...he just seems to love entertaining people, he just thinks it's hilarious, so "if I do this they'll laugh more".*

Emotion regulation.

As demonstrated in Table 37, significant reductions were found across the three time points for Jessica's overall emotion dysregulation, limited access to emotion regulation strategies, and for lack of emotional clarity, although this facet only decreased between post-program and six-month follow-up. Wilcoxon Signed Ranks Tests demonstrated significant reductions between pre-program and six-month follow-up for overall emotion dysregulation (z = -2.44, p = .01) and limited access to emotion regulation strategies (z = -2.71, p = .007). Overall, it seems that most aspects of emotion regulation improved following the program, and most of these gains were sustained six-months later. While Jessica's emotional awareness and acceptance of emotional responses did not improve post-program, it appears that her emotional awareness had improved at six-month follow-up.

Table 37

Jessica: Emotion Regulation Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 ($df = 2$)	*n*
DERS	126	119	109	9.28*	36
Nonacceptance of Emotion Responses	19	19	22	1.33	6
Difficulties in Goal-Directed Behaviour	23	20	23	3.60	5
Impulse Control Difficulties	22	20	19	1.30	6
Lack of Emotional Awareness	17	20	15	3.52	6
Limited Access to Emotion Regulation Strategies	25	20	16	10.64**	8
Lack of Emotional Clarity	20	20	14	6.40*	5
DSI					
Emotional Reactivity	59	56	55	2.00	11
Emotional Cutoff	33	33	34	0.07	12

*p<.05

**p<.01

Jessica identified an improvement in her emotion regulation abilities and concurrently in her mood following the program:

> *My mood is – it's somewhat improved. Still varies a lot, still goes up and down a lot, but I'd say there's some improvement in it, yeah. Or in me being able to manage it.*

Six months later Jessica reported a reduction in the negative emotional states she had experienced as a mother, stating that "I feel a little bit less overwhelmed and panicky", which she related to improved emotion regulation strategies, consistent with her quantitative profile.

Parenting stress.

As shown in Table 38, there were significant differences across the three time points for Jessica's overall parenting stress. Wilcoxon Signed Ranks Tests revealed significant reductions in parenting stress from post-program to six-month follow-up (z = -2.18, p = .03), and between pre-program and six-month follow-up (z = -2.13, p = .03). Overall, the reductions in parenting stress post-program seem to have been sustained at the six-month follow-up.

Table 38

Jessica: Parenting Stress Index (PSI) Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 (df = 2)	n
PSI	113	100	97	7.30*	33
Lack of Competence	39	35	35	2.10	13
Isolation	27	25	24	2.00	6
Attachment Dysfunction	16	13	14	4.67	7
Role Restriction	31	27	24	6.00	7

*p<.05

Following the program Jessica described how her thought process about her parenting ability had changed and influenced her emotional state. This appears to have contributed to reduced substance use and improved parenting self-efficacy.

> *Sometimes I used to feel a bit overwhelmed. And I'd go "Oh my god I've got to look after this person and they're totally relying on me and I always stuff things up and what if I stuff things up and they get hurt?" I feel a little bit less of that because I feel a little bit more confident, it leads to less of the overwhelmed feeling, which means I'm less likely to go "Well I need to take something to calm me down so I can deal with that"...it means that I feel less likely to feel that slightly overwhelmed, "Oh my goodness I'm not sure if I'm good enough to do this" sort of thing.*

Six months later Jessica reflected on how the change in her substance use had affected her parenting and how she perceives her ability as a mother:

> *I think just as I've gone on the longer I've been able to maintain sobriety the more able I've felt I've been able to be interactive with (son) and be there for him and be there for him without smothering him and I feel fairly balanced about that, so that's good.*

Depression, anxiety and stress.

As demonstrated in Table 39, there was a significant reduction in Jessica's level of depression across the three time points. While there was a non-significant trend for the total DASS to decrease from pre- to post-program, Wilcoxon Signed Ranks Tests revealed significant reductions at six-month follow-up, from pre-program (z = -2.50, p = .01) and from post-program (z = -2.50, p = .01). Relative to Australian norms, Jessica's score for depression was moderate at pre-program and post-program, then normal at six-month follow-up. Her anxiety score was normal at pre-program, then increased to moderate at post-program and returned to normal at six-month follow-up. Her stress score was severe at pre-program, decreased to moderate at post-program and returned to severe at six-month follow-up. Overall, Jessica's depression significantly improved post-program and further improved at six-month follow-up. However, her scores on anxiety and stress present a mixed picture with opposing trends shown.

Table 39

Jessica: Depression, Anxiety and Stress Scale (DASS) Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 ($df = 2$)	*n*
DASS	54	48	34	5.16	21
Depression	20	14	4	9.09*	7
Anxiety	6	14	4	5.16	7
Stress	28	20	26	3.50	7

*p<.05

Following the program Jessica portrayed an experience of lessened stress and anxiety, despite the quantitative increase in anxiety, which she associated with the development of her mindfulness skills resulting from the group.

> *Little phobias or little anxieties and emotions I was able to – I mean I was already aware of the mindfulness technique, but I was able to, obviously we really focused on it over the group. So I find I'm able to use that fairly well now. In moments of stress I'm able to use that mindfulness to write over it. And that's definitely gotten easier since having done the group.*

Consistent with Jessica's quantitative profile, at six-month follow-up a reduction in anxiety was reported:

> *I'm less, a bit less anxious.*

Attachment orientation.

As shown in Table 40, there was a non-significant trend in the hypothesised direction across the three time points for Jessica's attachment anxiety. Her attachment avoidance rating showed little change.

Table 40

Jessica: Experiences in Close Relationship Scale Short Form (ECR-S) Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 ($df = 2$)	*n*
ECR-S					
Anxiety	37	35	33	1.37	6
Avoidance	9	10	8	0.80	6

Jessica selected the general relationship styles that best described her in close relationships as assessed by the RQ. She selected the preoccupied attachment style at all three time points. This was consistent with her preoccupied attachment style ratings shown in Figure 4. At post-program, the fearful attachment style had the greatest decrease, while the secure attachment style had the greatest increase, with both styles returning to pre-program levels six months later.

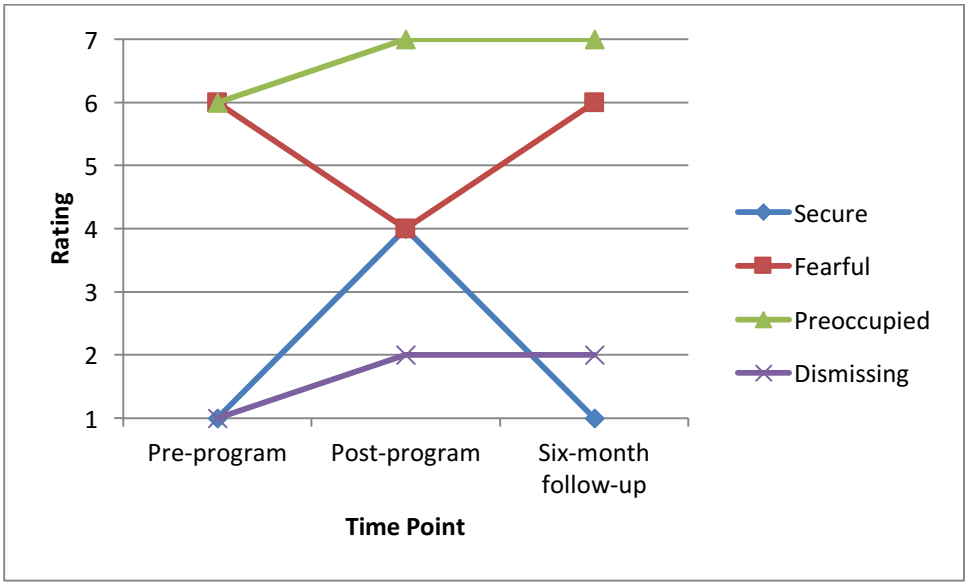

Figure 4. Jessica: Attachment style ratings.

Following the program Jessica identified an increase in assertiveness, which despite her quantitative profile indicates a reduction in her preoccupied attachment style, as people with a preoccupied attachment style tend to lack self-confidence and fear abandonment (Teyber & McClure, 2011). Her increased assertiveness and ability to experience anger is consistent with her reduced anxious-insecure attachment orientation. Jessica appears to have become more able to acknowledge her own needs since the program:

> *I found that I felt a little bit more assertive. I sometimes find myself allowing myself to get a little bit angrier than I used to. And that is a bit of a culture shock for (husband). He isn't used to me being assertive. He's only down with me being assertive if I'm going along with what he wants.*

Six months after the program Jessica demonstrated an application of attachment theory since her son had grown from an infant to a toddler, which is an important component of secure attachment.

> *I feel like I wanna be, make sure I'm available to him but give him plenty of space to explore for himself.*

9.6 Alena

Alena was single with one daughter aged 6 years. They lived together in small home behind her parents' house. On assessment using the SCID, she met subthreshold levels of BPD as she endorsed 3 of 9 BPD criteria. Prior to attending the MPG-BPD program Alena reported low-range BPD symptom severity relative to the other participants on the PDQ-4+ (19 out of a possible 36) and the BEST (low to mid-range).

BPD symptom severity.

As shown in Table 41, there were no significant changes in Alena's BPD symptom severity across the three time points. Alena's PDQ-4+ ratings did not change following the program and only slightly decreased six months later, while her total BEST score increased slightly following the program and did not change six months later. Overall, little change in BPD symptom severity was apparent for Alena.

Table 41

Alena: BPD Symptom Severity Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 ($df = 2$)	*n*
PDQ-4+					
BPD Symptoms	19	19	18	2.00	9
BEST	26	27	27	0.07	16
Thoughts and Feelings	18	19	16	0.74	8
Behaviours - Negative	5	5	5	0.00	4
Behaviours - Positive	12	12	9	4.00	3

Despite little quantitative change being evident for BPD symptom severity, following the program Alena described an increased awareness of her tendency to devalue others when she feels they are not 'there' for her enough, as her friend did not come to help her when her car broke down. The following quote illustrates Alena's increased reflective functioning in relation to self and others, which seems to have stabilised her interpersonal emotional responses:

> *I had a bit of friction with my friend when my car broke down. Now that really upset me. Normally I'd probably broach the subject again at some point, or totally avoid her, which would escalate it. But again I just took a step back, waited it out more than I normally would. Because before like "I don't care she's not my friend anymore" but this time – I don't want to lose this friendship so I've just got to really step back, bide my time, wait, try and think clearly, because there's a pattern going on with me losing friends, and maybe it's the way I deal with these scenarios. To a point, I mean it takes two, but to a point. So just not getting so heated up about things and not playing the victim and trying to realize that other people have their own issues as well, it may not be always to do with me specifically. It doesn't mean I'm not still upset about things, it's just – from experience now waiting it out and it sorts itself out, just understanding that friendships go through phases, from an adult perspective, and I don't look at it through a childish perspective like I have a tendency to do.*

Alena also reported an improved relationship with her parents since the program, which appears to be associated with lessened reactivity to interpersonal stress:

> *I think there's only been that one blow-up and I have noticed things were a little bit more – what's the word? Less volatile, I think you'd have to say. There's still times where you can see it looking like it might escalate so you just keep your mouth shut.*

Six months later, she reported that this had been maintained and indicated that this related to an improved ability to control anger and reduced reactivity of mood.

> *It's not as bad. There's always that tension but I've just stopped, with a few exceptions, just trying to let it wash over me a little bit and not bite back ask much....You have to really bite your tongue and I've just gotten a bit better at doing that. So I would say that's a bit of a change there, a bit of an improvement. Whereas before I'd probably snap back. I just try to be a bit more chilled out about it.*

Despite Alena's quantitative profile, her own report indicates that following the program and six months after the program, her BPD symptom severity had decreased for three BPD criteria: affective instability due to a marked reactivity of mood, difficulty controlling anger, and a pattern of unstable and intense interpersonal relationships.

Mindfulness.

As shown in Table 42, there was a significant increase for the non-reactivity to inner experience facet of mindfulness across the three time points, with a Wilcoxon Signed Ranks Tests revealing a significant increase from pre- to post-program ($z = 2.12$, $p = .03$), and from pre-program to six-month follow-up ($z = 2.46$, $p = .01$). A significant increase was also found for Alena's overall mindfulness ($z = 2.18$, $p = .03$) at post-program, which then slightly decreased six-months later.

Table 42

Alena: Five Facet Mindfulness Questionnaire (FFMQ) Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 ($df = 2$)	*n*
FFMQ	94	108	105	3.91	39
Observing	23	23	23	0.33	8
Describing	15	20	19	2.00	8
Acting with Awareness	25	27	25	1.00	8
Non-Judging of Inner Experience	21	22	19	1.53	8
Non-Reactivity to Inner Experience	10	16	19	11.27**	7

**p<.01

Six months after the program, Alena reflected on her increased mindfulness and illustrated how her ability to act with awareness resulted in less emotional reactivity and a greater sense of purpose.

> *Even though I'm not continually practicing the mindfulness but in itself I've become a bit more aware of what I'm doing. Try to still myself. I actually did it yesterday; I was a bit all over the place with things that are happening at the moment. And I just had to stop and stand there and do nothing, and I could feel myself calm down...I just seem to get a lot more done, I seem to have a bit more direction.*

Parental reflective functioning.

As shown in Table 43, contrary to predictions, Alena's overall parental reflective functioning and lack of certainty about mental states (being less likely to think she can be a mind reader) significantly decreased across the three time points, with a significant difference found between pre-program and six-month follow-up for lack of certainty about mental states (z = -2.07, p = .04). Overall, it seems that reflective functioning did not significantly improve, although there were some inconsistent oscillations suggesting that, immediately post-program, Alena had a greater tendency towards mentalizing modes of thinking, while at the same time point she showed a trend of reduced interest and curiosity about her child's mental states and was more likely to assume she could read others' minds.

Table 43

Alena: Parental Reflective Functioning Questionnaire (PRFQ) Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 (df = 2)	n
PRFQ	107	105	97	6.69*	18
Mentalizing	33	37	33	2.60	6
Lack of Certainty about Mental States	36	33	28	8.38*	6
Interest and Curiosity about Mental States	38	35	36	2.00	6

*p<.05

Following the program Alena was aware of an improved relationship with her daughter, and related this to increased mindfulness. This appears to be associated with an increased awareness of mental states that underlie her child's behaviour, and suggests increased reflective functioning despite her quantitative profile. The following quote demonstrates Alena's reflection of her daughter's mental state.

> *Other little things have changed. She used to have quite a bad tic at one stage. I thought "Oh no here we go, another one in the family". But that's gone and I think that was a nervous thing and I just think it was a – it could have been a coincidence but I thought it was a symptom of how we were going at the time. Which timing wise it probably makes sense.*

Emotion regulation.

As demonstrated in Table 44, significant differences in the hypothesised direction were found across the three time points for Alena's overall emotion dysregulation, nonacceptance of negative emotions, impulse control difficulties, lack of emotional awareness, and limited access to emotion regulation strategies. Closer examination using Wilcoxon Signed Ranks Tests revealed significant reductions from pre- to post-program for overall emotion dysregulation (z = -3.89, p = .00) and impulse control difficulties (z = -2.25, p = .02), with a significant decrease from pre-program to six-month follow-up for her overall emotion dysregulation (z = -2.66, p = .008). However, effects were not sustained as there were significant increases between post-program and six-month follow-up for overall emotion dysregulation (z = 2.47, p = .01) and impulse control difficulties (z = 2.00, p = .046), although levels remained below those at pre-program. Similar patterns of reductions were found immediately post-program for nonacceptance of negative emotions (z = -2.07, p = .04), and then a trend of increasing at the six-month follow-up, and for limited access to emotion regulation

strategies there was a trend of reducing at post-program but then significantly increasing at the six-month follow-up ($z = 2.33$, $p = .02$). Overall the pattern was one of initial improvement post-program, but these improvements fell away at the six-month follow-up, although emotional dysregulation generally remained below pre-program levels.

Table 44

Alena: Emotion Regulation Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 ($df = 2$)	*n*
DERS	127	93	110	23.13***	36
Nonacceptance of Emotion Responses	22	14	20	7.00*	6
Difficulties in Goal-Directed Behaviour	16	13	16	2.00	5
Impulse Control Difficulties	20	11	15	10.00**	6
Lack of Emotional Awareness	23	22	17	6.13*	6
Limited Access to Emotion Regulation Strategies	24	18	25	7.60*	8
Lack of Emotional Clarity	22	15	17	5.65	5
DSI					
Emotional Reactivity	53	52	48	3.70	11
Emotional Cutoff	54	50	50	2.55	12

*p<.05

**p<.01

***p<.001

Six months after the program Alena demonstrated an increased awareness of and ability to identify her emotions, which appears to have resulted in self-care:

> *So just not taking as much on and seeing the difference between feeling calm and feeling really overwhelmed and it took me awhile to realise that I just couldn't take anymore. I had never noticed that before.*

In Alena's description of her response to an issue with her ex-partner, she illustrates a reduction in her emotional reactivity and an increased acceptance of the situation:

> *Yeah but where I would have reacted to it a year ago, tearing my hair out and panicking and running to everyone going he's such a bastard...This has happened and I just have to keep going, and that wasn't like that before.*

These quotes alongside Alena's quantitative profile indicate that several aspects of emotion regulation had developed for Alena since the program.

Parenting stress.

As demonstrated in Table 45, there were non-significant trends in the hypothesised direction for Alena's overall parenting stress and isolation across the three time points, and for a reduction in her feelings of lack of parenting competence post-program, although this was not sustained at the six-month follow up. Attachment dysfunction and role restriction had no change from pre- to post-program, although there was a non-significant trend for these to decrease at six-month follow-up.

Table 45

Alena: Parenting Stress Index (PSI) Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 ($df = 2$)	*n*
PSI	110	103	99	0.50	33
Lack of Competence	38	32	37	5.25	13
Isolation	23	22	21	1.00	6
Attachment Dysfunction	18	18	14	3.85	7
Role Restriction	31	31	27	6.00	7

Following the program Alena reflected on a change in the relationship with her daughter, which appeared to impact positively on her sense of parenting self-efficacy as demonstrated by her post-program improvement in parenting confidence.

> *I feel like she trusts me more...a couple of times now we walk to school, and she's actually walking along and she's like "I've got my eyes closed!" And I said "Why?" And she's like "Well I trust you" to get her there, just trusts me to guide her, "Okay we're stopping at the road, we've got a driveway". And I think that's a new thing, it didn't happen before.*

Depression, anxiety and stress.

As shown in Table 46, significant differences in the hypothesised direction were found across the three time points for Alena's level of depression. Closer examination using Wilcoxon Signed Ranks Tests revealed significant reductions from pre- to post-program for total DASS (z = -3.21, p = .001), depression (z = -2.00, p = .046) and stress (z = -2.12, p = .03), with a significant reduction in depression between pre-program and the six-month follow-up (z = -2.00, p = .046). At the six-month follow-up there was a non-significant trend for the total DASS ratings to increase but remain below pre-program levels and for stress to return to baseline levels. Relative to Australian norms, Alena's score for depression was moderate at pre-program, then decreased to normal at post-program with this level maintained at six-month follow-up. Her anxiety score was mild at pre-program, and decreased to normal at post-program and six-month follow-up; and her stress was moderate pre-program, then normal at post-program, and returned to moderate at six-month follow-up.

Table 46

Alena: Depression, Anxiety and Stress Scale (DASS) Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 ($df = 2$)	*n*
DASS	44	20	34	12.19**	21
Depression	16	8	8	6.40*	7
Anxiety	8	4	6	2.00	7
Stress	20	8	20	6.78*	7

*p<.05

**p<.01

Consistent with her quantitative profile, Alena was aware that her mood had improved since the program and described the impact this had on her behaviour:

> *I just felt like I'm suddenly – I'm making a bit more of an effort. Not every day, it still depends how I feel, but I feel more often like leaving the house like a civilized human being. And I can see that I behave differently and people respond differently...The fact that I don't want to leave the house looking so horrid most days counts for something too. So the fact that I'm not sort of trudging, moping around like "I don't care, don't give a shit what people think" or whatever, is a change.*

Six months later, she indicated that the reduction in lowered mood had been maintained, and related this to her response to an increased awareness of how things were impacting on her.

> *So I think there is a better outlook in general, and the moods are less because I'm taking a step back from things that were really weighing down on me as well.*

Attachment orientation.

As shown in Table 47, there was a non-significant trend for Alena's attachment anxiety to increase from pre- to post-program, and then slightly decrease at six-month follow-up, whereas attachment avoidance showed little change.

Table 47

Alena: Experiences in Close Relationship Scale Short Form (ECR-S) Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 ($df = 2$)	*n*
ECR-S					
Anxiety	27	34	32	4.77	6
Avoidance	22	24	25	0.62	6

Alena selected the general relationship styles that best described her in close relationships as assessed by the RQ. She selected the fearful attachment style at all three time points, which was consistent with attachment style ratings shown in Figure 5. The dismissing attachment style had the greatest decrease from pre- to post-program, and alongside the secure attachment style, had the lowest rating at post-program.

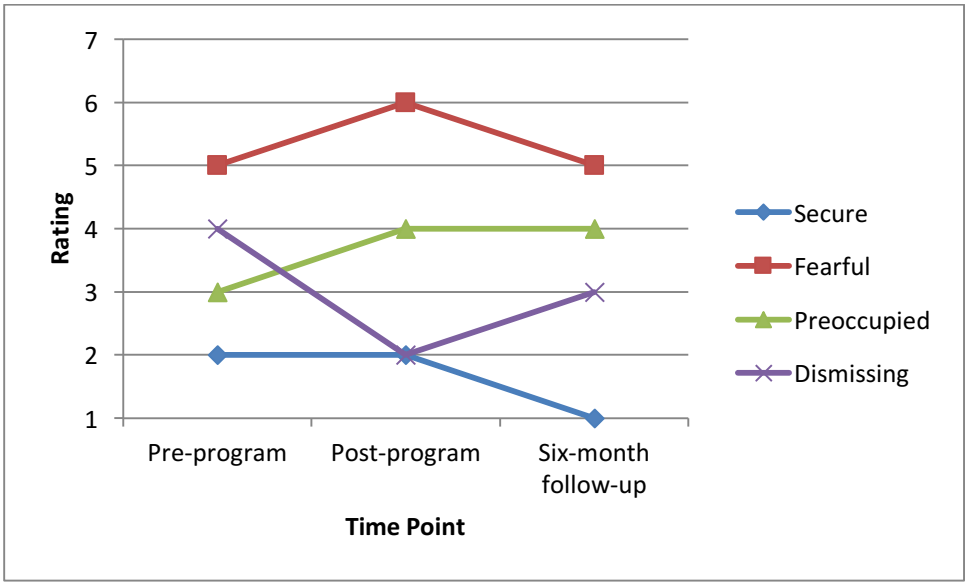

Figure 5. Alena: Attachment style ratings.

This reduction in the dismissing attachment style is illustrated by the change in Alena's attitude towards interacting with her daughter in the following quotes. Prior to the program Alena reported:

> *She's often got to ask me to play with her and I'm like "Oh do I have to, do I need to?" I don't find it fun a lot of the time, I find it a bit of a chore in some ways.*

Following the program Alena expressed that she was:

> *Trying a little bit harder to do things together and not always use them as lessons, not always as teaching experiences. Like when we throw the ball, just let her drop it let her muck around let her throw it between her legs, and try to keep my mouth shut and just do it. Just trusting her more.*

Six months later Alena described an increased awareness of her parenting style being modelled on her own experience of being parented, and how she was being more mindful of this with her daughter:

> *I'm trying to treat her more like a person, I feel like I disrespect her sometimes. I would never talk to a friend how I sometimes talk to my daughter and I try to remind myself of that. I think I'm getting better, but sometimes I need to try harder. I try to remind myself not to speak to her rudely, to not to take it out on a little kid when she does something wrong. That's how we were brought up.*

9.7 Kylie

Kylie was single with one son aged 6 years. On assessment using the SCID, Kylie met criteria for Bipolar II Disorder, Posttraumatic Stress Disorder, chronic in duration, and BPD with five criteria endorsed. Prior to attending the MPG-BPD program Kylie reported mid to high-range BPD symptom severity relative to the other participants, as she had the second highest ratings on the PDQ-4+ (23 out of a possible 36) and on the BEST (mid-range).

BPD symptom severity.

As demonstrated in Table 48, there were significant reductions in Kylie's BPD symptom severity across the three time points, as measured by the PDQ-4+, total BEST score, and ratings of thoughts and feelings associated with BPD. Wilcoxon Signed Ranks Tests revealed a significant decrease in the PDQ-4+ from pre-program to six-month follow-up (z = -2.07, p = .04), a reduction in her total BEST from pre- to post-program (z = -2.94, p = .003) and from pre-program to six-month follow-up (z = -3.07, p = .002). There was a significant decrease in her ratings of thoughts and feelings associated with BPD from pre- to post-program (z = -2.42, p = .02), and between pre-

program and six-month follow-up (z = -2.41, p = .02). For Kylie, the general pattern was for a reduction in BPD symptom severity across the three time points.

Table 48

Kylie: BPD Symptom Severity Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 (df = 2)	n
PDQ-4+					
BPD Symptoms	23	19	15	7.3*	9
BEST	47	28	24	14.98**	16
Thoughts and Feelings	27	15	13	9.92**	8
Behaviours - Negative	11	5	6	3.50	4
Behaviours - Positive	6	7	10	3.71	3

*p<.05

**p<.01

Kylie reported less difficulty controlling anger and an improved self-image following the program. This was consistent with these strong quantitative improvements further demonstrating a reduction in her symptom severity for two BPD criteria.

> *I'm less likely to do something because I'm frustrated or upset. I can catch myself before I just lose it.*

> *Life's too short for always having drama or issues or – and it's situations you put yourself in. It's not that it's just life working against you, you put yourself in situations so why put yourself in the situations to begin with? And I just can't be bothered, because it's wasting my time, yeah… I'm worth more than drama. I'm just worth more in general, I deserve better.*

Mindfulness.

As shown in Table 49, there were significant differences in Kylie's overall mindfulness, and in the mindfulness facets of describing and non-reactivity to inner experience across the three time points. Wilcoxon Signed Ranks Tests revealed significant increases from pre- to post-program and between pre-program and six-month follow-up for overall mindfulness ($z = 4.08$, $p = .00$; $z = 3.12$, $p = .002$), describing ($z = 2.60$, $p = .009$; $z = 2.25$, $p = .02$) and non-reactivity to inner experience ($z = 2.46$, $p = .01$; $z = 2.45$, $p = .01$). Generally, the pattern was that of improved mindfulness post-program, and although trends were for a slight reduction at the six-month follow-up, these gains still remained significant.

Table 49

Kylie: Five Facet Mindfulness Questionnaire (FFMQ) Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 ($df = 2$)	*n*
FFMQ	85	112	107	20.57***	39
Observing	18	21	21	1.73	8
Describing	21	32	30	12.00**	8
Acting with Awareness	18	22	24	4.52	8
Non-Judging of Inner Experience	21	21	19	0.64	8
Non-Reactivity to Inner Experience	7	16	13	12.09**	7

**p<.01

***p<.001

Kylie demonstrated an awareness of increased mindfulness following the program, and attributed this to "practicing in the group… talking about it and learning about it and understanding it".

I tend to be more mindful and I realise that I'm doing it, so I enjoy it more.

Parental reflective functioning.

As indicated in Table 50, no significant changes were found for parental reflective functioning, with trends immediately post-program indicating a reduction in reflective functioning followed by an increase at the six-month follow-up with her overall parental reflective functioning and interest and curiosity in her child's mental states increasing to pre-program levels at the six-month follow-up. Overall, it seems that reflective functioning did not significantly improve, although the likelihood that Kylie would assume she could read others' minds had decreased six-months after the program, which was an improvement on this tendency pre-program.

Table 50

Kylie: Parental Reflective Functioning Questionnaire (PRFQ) Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 ($df = 2$)	*n*
PRFQ	103	92	102	3.73	18
Mentalizing	40	37	35	5.00	6
Lack of Certainty about Mental States	28	26	33	1.83	6
Interest and Curiosity about Mental States	35	29	34	3.90	6

Kylie did not indicate an increase in parental reflective functioning during the interviews, which supports these quantitative findings.

Emotion regulation.

As shown in Table 51, significant differences were found across the three time points for Kylie's overall emotion dysregulation, impulse control difficulties, lack of emotional awareness, limited access to emotion regulation strategies, and lack of emotional clarity. Wilcoxon Signed Ranks Tests found significant reductions from pre- to post-program and between pre-program and six-month follow-up for Kylie's overall emotion dysregulation (z = -3.67, p = .00; z = -4.44, p = .00), impulse control difficulties (z = -2.04, p = .04; z = -2.04, p = .04), and limited access to emotion regulation strategies (z = -2.26, p = .02; z = -2.60, p = .009). A significant decrease in emotional reactivity was found between pre-program and six-month follow-up (z = -2.11, p = .04). While there was no change in lack of emotional awareness from pre- to post-program, there was a significant decrease between post-program and six-month follow-up (z = -2.12, p = .03). Non-significant trends on other emotion regulation variables correspond generally with this reduction in emotion dysregulation so that overall changes post-program were maintained at the six-month follow-up.

The following quote demonstrates Kylie's improved emotion regulation strategies and impulse control following the program:

> *Just in general everyday life when I'm about to lose it at (son) I try and take a breath or re-think why I'm about to yell or scream.*

Table 51

Kylie: Emotion Regulation Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 ($df = 2$)	*n*
DERS	133	105	95	29.78***	36
Nonacceptance of Emotion Responses	19	19	13	3.00	6
Difficulties in Goal-Directed Behaviour	16	12	15	3.82	5
Impulse Control Difficulties	24	14	15	7.90*	6
Lack of Emotional Awareness	22	22	16	7.63*	6
Limited Access to Emotion Regulation Strategies	36	27	25	12.00**	8
Lack of Emotional Clarity	16	11	11	8.00*	5
DSI					
Emotional Reactivity	52	47	45	4.92	11
Emotional Cutoff	28	29	25	0.79	12

*p<.05

**p<.01

***p<.001

Parenting stress.

As shown in Table 52, there was a significant reduction in the hypothesised direction across the three time points for Kylie's sense of isolation, although Wilcoxon Signed Ranks Tests did not differentiate between time points. Overall, apart from attachment dysfunction, it seems that Kylie's parenting stress showed a trend of decreasing following the program and these gains were sustained six-months later, with isolation demonstrating significant improvement over time.

Table 52

Kylie: Parenting Stress Index (PSI) Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 ($df = 2$)	*n*
PSI	109	99	94	3.28	33
Lack of Competence	52	43	39	2.48	13
Isolation	25	24	22	6.50*	6
Attachment Dysfunction	9	11	11	2.67	7
Role Restriction	23	21	22	0.40	7

*p<.05

Following the program Kylie demonstrated confidence in her parenting abilities, and indicated that the development of mindfulness has resulted in an improved sense of parenting self-efficacy.

> *I know that he's loved, he's cared for, I love – yeah he's well looked after, he's a spoilt little brat at times but he's a good kid and he's well looked after and I raise him well. And being in the moment has given me – now – has given me… It's given me the self-belief.*

Consistent with her quantitative profile, Kylie's sense parenting self-efficacy appears to have been maintained six months later:

> *I'm able to enjoy my time with him more because I'm not stressing and second-guessing myself.*

Depression, anxiety and stress.

As shown in Table 53, Kylie's total DASS, depression, and stress ratings demonstrated non-significant trends in the hypothesised direction across the three time points. Relative to Australian norms, Kylie's scores for depression and anxiety were moderate at all three time points, and her stress was extremely severe at pre-program

and reduced to moderate at post-program. This level was maintained at six-month follow-up.

Table 53

Kylie: Depression, Anxiety and Stress Scale (DASS) Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 ($df = 2$)	*n*
DASS	66	54	52	4.00	21
Depression	18	16	14	1.20	7
Anxiety	14	14	14	0.29	7
Stress	34	24	24	5.33	7

Following the program Kylie was aware of changes in her thought process that helped this reduction in stress.

> *Like my sister's coming tonight so usually that would stress me and I'm going to go home and clean anyway. But my house isn't dirty, it's not – if it's untidy it's untidy because we've been there, and we're living in it, like it's a home not a house. So that used to stress me through the roof and now it's like no, well I do – I'm not as bad as – yeah and half the time it's only in my own head anyway.*

Six months later, Kylie identified her use of mindfulness techniques and the impact this had on her level of anxiety, despite the lack of quantitative change:

> *Trying to sleep of a night time when my brain's going a million miles an hour. Just the breathing and the relaxing and trying to calm, just let everything pass through my brain instead of jumping on each separate thought helps me relax and get to sleep a lot quicker.*

Attachment orientation.

As shown in Table 54, there was a significant change across the three time points for Kylie's anxious-insecure attachment orientation. Wilcoxon Signed Ranks Tests revealed a significant decrease in attachment anxiety between pre-program and six-month follow-up (z = -2.04, p = .04), and from post-program to six-month follow-up (z = -2.04, p = .04). There was a non-significant trend of decreased attachment avoidance from pre- to post-program, with no change at the six-month follow-up.

Table 54

Kylie: Experiences in Close Relationship Scale Short Form (ECR-S) Scores and Friedman Tests

	Pre-program	Post-program	Follow-Up	χ^2 (df = 2)	n
ECR-S					
Anxiety	27	29	17	7.50*	6
Avoidance	16	13	13	0.30	6

*p<.05

Kylie selected the general relationship styles that best described her in close relationships as assessed by the RQ. She selected the fearful attachment style at pre-program, preoccupied at post-program, and fearful six months later, which is consistent with Kylie's attachment style ratings shown in Figure 6. The secure and dismissing attachment styles both increased across the three time points, with the secure attachment style rated the second highest at six-month follow-up.

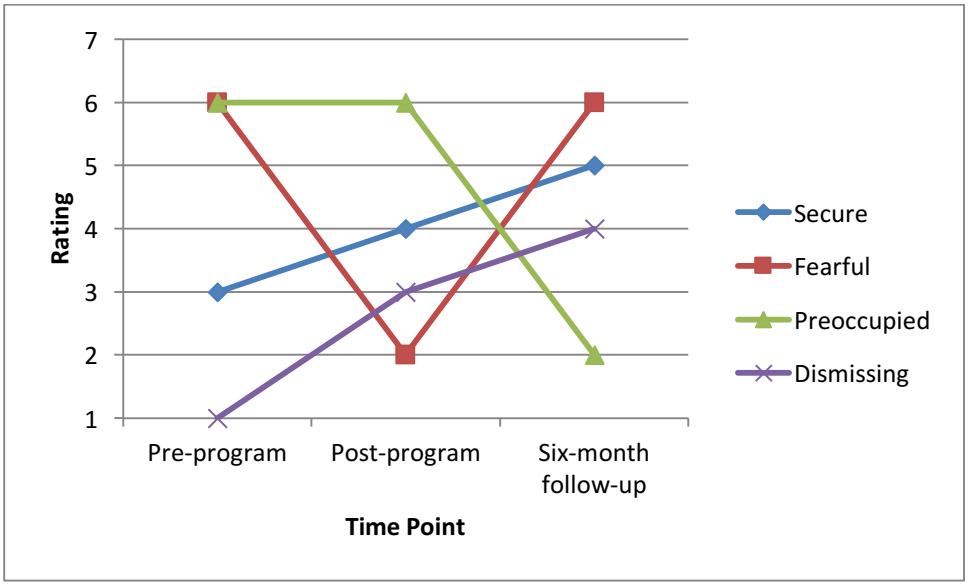

Figure 6. Kylie: Attachment style ratings.

9.8 Daria

Daria was single with one daughter aged 24 years and one son aged 7 years. On assessment, Daria was regularly using substances and met criteria for Substance Dependence, Substance Induced Mood Disorder, Substance Induced Anxiety Disorder, Posttraumatic Stress Disorder, and BPD with seven criteria endorsed using the SCID. Prior to attending the MPG-BPD program Daria reported mid to high-range BPD symptom severity relative to the other participants on the PDQ-4+ (22 out of a possible 36) and the BEST (mid-range).

BPD symptom severity.

As shown in Table 55, there was a significant reduction in Daria's BPD symptom severity from pre- to post-program as measured by her total BEST score, with a non-significant trend of decreased PDQ-4+ ratings found. A closer examination of the BEST subscales revealed non-significant trends for thoughts and feelings associated with BPD to decrease from pre- to post-program, and for ratings of positive behaviours to increase. There was no change in ratings of negative behaviours.

Table 55

Daria: BPD Symptom Severity Scores and Wilcoxon Signed Ranks Tests

	Pre-program	Post-program	*z*	*n*
PDQ-4+				
BPD Symptoms	22	17	-1.10	9
BEST	37	24	-2.24*	15
Thoughts and Feelings	20	12	-1.95	8
Behaviours - Negative	9	9	0.38	4
Behaviours - Positive	7	12	1.07	3

*p<.05

Following the program Daria described a reduction in her reactivity of mood, reflecting this decrease in BPD associated thoughts and feelings, as well as the consequent impulsivity with substance use, despite the lack of quantitative change in negative behaviours:

> *I've had some bad days and I've dealt with them better. They haven't hit me as hard as a down day would have in the past. Like I would have relapsed and gone and used and stuff, whereas I haven't. So there's been different responses with the substance abuse.*

Further support for the change in thoughts and feelings post-program is provided by the following quote where Daria illustrated an awareness of how mindfulness had resulted in her anger decreasing in intensity and an improved ability to control it:

> *It's a totally different ballpark now that I'm being mindful...with my aggressive emotional state it's had a real impact there.*

These quotes further demonstrate the reduction in Daria's BPD symptom severity for three BPD criteria: intense anger or difficulty controlling anger, affective instability due to a marked reactivity of mood, and impulsivity in a self-damaging area.

Mindfulness.

As demonstrated in Table 56, significant increases were found from pre- to post-program for Daria's overall mindfulness and the observing facet of mindfulness. Trends of improvements on the other dimensions of mindfulness were apparent except for non-judging of inner experience which decreased between pre- and post-program, indicating that Daria had particular difficulty with this aspect of mindfulness.

Table 56

Daria: Five Facet Mindfulness Questionnaire (FFMQ) Scores and Wilcoxon Signed Ranks Tests

	Pre-program	Post-program	*z*	*n*
FFMQ	75	92	2.53*	39
Observing	9	20	2.60**	8
Describing	21	23	0.82	8
Acting with Awareness	12	18	1.73	8
Non-Judging of Inner Experience	23	18	-1.41	8
Non-Reactivity to Inner Experience	10	13	1.34	7

*p<.05

**p<.01

Following the program Daria reflected on how increased mindfulness, particularly acting with awareness, influenced her level of awareness and decision making, especially in relation to her substance use.

> *Never before… actually thought consciously. Never made a mindful decision before your course.*

> *Everything was just auto-pilot – I made conscious decisions before, but I wasn't mindful of those decisions, and there's a difference.*

Parental reflective functioning.

As shown in Table 57, Daria showed contrary trends on the various indicators of parental reflective functioning. Opposite to predictions, there was a significant decrease in her overall parental reflective functioning, and a non-significant trend of decreased mentalizing post-program, although there was an opposing trend towards increased interest and curiosity about her child's mental states.

Table 57

Daria: Parental Reflective Functioning Questionnaire (PRFQ) Scores and Wilcoxon Signed Ranks Tests

	Pre-program	Post-program	*z*	*n*
PRFQ	110	107	-2.12*	18
Mentalizing	40	31	-1.89	6
Lack of Certainty about Mental States	37	38	1.00	6
Interest and Curiosity about Mental States	33	38	1.63	6

*p<.05

Following the program, Daria's report of changes she had experienced as a mother was consistent with her quantitative profile. The following quote illustrates her increased interest and curiosity in her son's mental states as well as her recognition of a lack of certainty about his mental states; indicating that these aspects of Daria's reflective functioning had developed over the course of the program.

> *Since the group…I believe I have better understanding of (son). I think that's because I've given the time to try to deal with whatever – like I was complaining I didn't know [him], I didn't understand, so I was starting to actually ask. Which then gave me the answers from him to then start thinking about these – before I'd actually start speaking with (son).*

Emotion regulation.

As shown in Table 58, significant reductions were found for Daria's overall emotion dysregulation, difficulties in goal-directed behaviour, lack of emotional awareness, and limited access to emotion regulation strategies, with non-significant trends for a reduction on most other emotion dysregulation variables.

Table 58

Daria: Emotion Regulation Scores and Wilcoxon Signed Ranks Tests

	Pre-program	Post-program	*z*	*n*
DERS	125	76	-4.63***	36
Nonacceptance of Emotion Responses	16	13	-1.73	6
Difficulties in Goal-Directed Behaviour	20	10	-2.04*	5
Impulse Control Difficulties	20	14	-1.51	6
Lack of Emotional Awareness	27	17	-2.24*	6
Limited Access to Emotion Regulation Strategies	22	10	-2.41*	8
Lack of Emotional Clarity	20	12	-1.84	5
DSI				
Emotional Reactivity	32	32	0.18	11
Emotional Cutoff	25	27	0.59	12

*p<.05

***p<.001

Following the program Daria reflected on her past avoidance of difficult emotions, and demonstrated a growing awareness and understanding of her emotions:

> *I didn't want to think about things before I guess. I don't know I just wasn't conscious of it, I wasn't aware. I'm getting more aware now of my emotions, and what causes certain emotions.*

This is consistent with her quantitative profile, and indicates that Daria's improved emotion regulation abilities are an outcome of the MPG-BPD program.

Parenting stress.

As demonstrated in Table 59, there were non-significant trends from pre- to post-program in the hypothesised direction for Daria's overall parenting stress, lack of parenting competence, isolation, attachment dysfunction, and role restriction.

Table 59

Daria: Parenting Stress Index (PSI) Scores and Wilcoxon Signed Ranks Tests

	Pre-program	Post-program	*z*	*n*
PSI	76	69	-0.04	33
Lack of Competence	35	31	-0.34	13
Isolation	11	10	-0.45	6
Attachment Dysfunction	14	13	-1.63	7
Role Restriction	16	15	-1.00	7

The quantitative findings are supported by the following quote in which Daria indicated that she was proud of changes in her parenting abilities as she described having implemented structure and predictability in her son's life, which she had previously found challenging due to her level of substance use.

> *A lot of the routine that I've initiated in the morning with the dress routine, breakfast, it's the wake-up routine, the schedule now that I've got in place we follow the same schedule every morning, it just works so well.*

Depression, anxiety and stress.

As shown in Table 60, there were non-significant reductions in Daria's DASS total score, depression, and stress from pre- to post-program. Her anxiety did not change post-program. Daria's score for depression was mild at pre-program then normal at post-program, her anxiety was moderate at pre- and post-program, and her stress was moderate pre-program then mild at post-program relative to Australian norms.

Table 60

Daria: Depression, Anxiety and Stress Scale (DASS) Scores and Wilcoxon Signed Ranks Tests

	Pre-program	Post-program	*z*	*n*
DASS	48	40	-0.97	21
Depression	10	8	-1.00	7
Anxiety	14	14	0.00	7
Stress	24	18	-1.34	7

Despite small changes in her quantitative profile, Daria depicted a reduction in the frequency of low moods following the program:

> *There's less downs…it has been a lot better…it's not as though I haven't had bad days since the group, but I haven't had a down.*

Attachment orientation.

As shown in Table 61, contrary to predictions there was a significant increase in Daria's attachment avoidance and a non-significant trend of increased attachment anxiety from pre- to post-program.

Table 61

Daria: Experiences in Close Relationship Scale Short Form (ECR-S) Scores and Wilcoxon Signed Ranks Tests

	Pre-program	Post-program	*z*	*n*
ECR-S				
Anxiety	10	15	1.13	6
Avoidance	9	28	2.04*	6

*p<.05

Daria selected the general relationship styles that best described her in close relationships as assessed by the RQ. She selected the fearful attachment style at pre-program and the secure attachment style at post-program, which was not consistent with her ECR-S ratings. However, Figure 7 shows that, Daria rated the fearful and preoccupied attachment styles the highest at pre-program and these decreased at post-program, while the initially lowest rated secure attachment style increased to the highest rating alongside the fearful attachment style post-program.

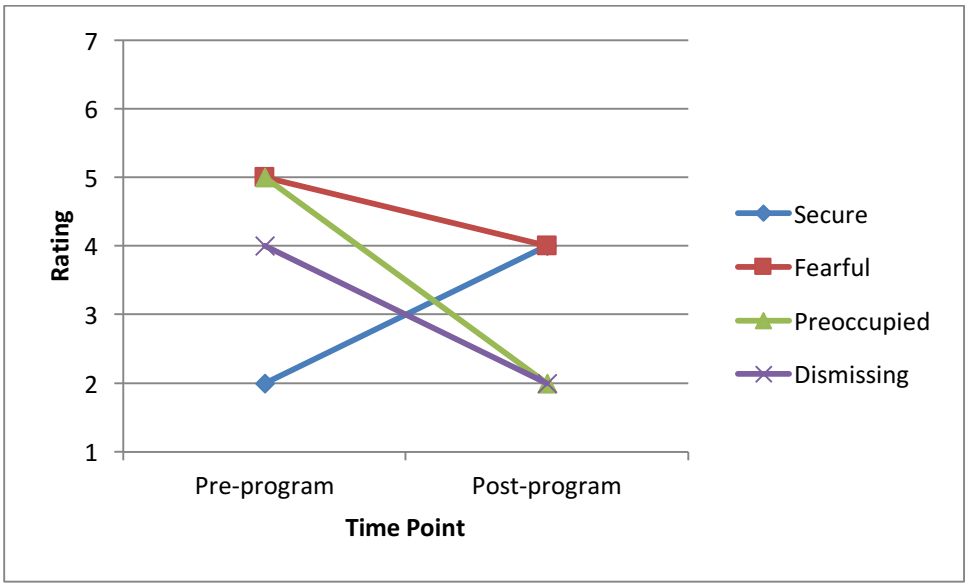

Figure 7. Daria: Attachment style ratings.

9.9 Summary of Case Studies

The triangulation of case study results confirmed that the majority of participants reported reductions in BPD symptomatology following the program with quantitative and qualitative improvements converging for Kate, Kylie and Daria, quantitative improvements found for Fiona, and qualitative improvements found for Jessica and Alena. These improvements were generally sustained at the six-month follow-up. All participants, except for Aisyah, demonstrated quantitative increases in mindfulness following the program, with these results converging with qualitative findings for Kate, Fiona, Jessica, Kylie and Daria. These improvements were generally sustained at six-month follow-up. Aisyah demonstrated qualitative improvements in mindfulness at post-program, with quantitative improvements demonstrated at the six-month follow-up. The majority of participants demonstrated quantitative improvements in emotion regulation following the program, with these results converging with the qualitative findings for Kate, Kylie and Daria. These improvements were generally maintained at the six-month follow-up. Improvements for psychological distress (i.e., depression, anxiety, and stress) were found for the majority of participants at post-program. For Fiona and Alena, their total depression, anxiety, and stress quantitatively improved following the program, with Fiona's qualitative results converging with this finding. The post-program quantitative improvements in depression found for Kate and Alena converged with their qualitative results, and Alena and Jessica's post-program quantitative improvements in depression were sustained at the six-month follow-up. Qualitative improvements in stress and anxiety were found at post-program or at six-month follow-up for Aisyah, Jessica, Alena and Kylie.

Although parenting stress and reflective functioning did not quantitatively change for the majority of participants, the qualitative results indicated improvements

on these variables following the program with the majority of participants reporting increased parenting self-efficacy. Post-program reductions in a dominant insecure attachment style were demonstrated for Fiona, Jessica, Kylie and Daria, although these were only sustained at the six-month follow-up by Kylie, with no data available for Daria at this time point. Contrary findings applied for Kate, Aisyah and Alena who showed increases in a dominant insecure attachment style following the program, which were not sustained for Alena or Aisyah at the six-month follow-up, who tended to increase in their secure attachment at this time. Qualitative improvements in attachment behaviours were demonstrated by Kate, Fiona, Jessica and Alena following the program and also by Kate, Jessica, Alena and Aisyah at the six-month follow-up.

Chapter 10: Program Evaluation Results

All seven participants completed feedback questionnaires after each session, and four participants completed post-program feedback questionnaires (Kate, Fiona, Jessica, Alena). The same four participants also attended the post-program focus groups. Qualitative feedback for program evaluation was also obtained from session feedback questionnaires and individual interviews. A total of 134 quotes, which varied in length from a few words to a paragraph, comprised the data content for analysis. The program evaluation data was assessed using descriptive statistical analysis for the quantitative component of the program feedback questionnaires, and IPA was used for the qualitative analysis of the program feedback questionnaires, individual interviews and focus groups, in order to identify the program evaluation themes.

10.1 Quantitative Results

10.1.1 Program feedback questionnaires.

Participants (n = 4) rated how helpful components of the MPG-BPD program were for them and their concerns on a scale from 1 (not helpful at all) to 10 (extremely helpful). The mean rating of the program activities was 8.25, with a range of 7 to 10. The mean rating of the program discussions was 9.25, with a range of 8 to 10. On the same 10-point scale, participants rated how helpful they considered mindfulness to be for them as a mother, M = 8.5, with a range of 7 to 10; and in their life generally, M = 8.75, with a range of 7 to 10.

10.1.2 Session feedback questionnaires.

A total of 61 session feedback questionnaires were completed, as not all participants attended every session.

10.1.2.1 Session activities and discussions.

Participants rated the session activities and discussions on a scale from 1 (not relevant at all) to 10 (highly relevant).

Table 62

Ratings of usefulness/relevance of session activities and discussions

	N	*M*	*SD*	*Range*
Session 1 Mindfulness and Parenting Introduction	7	8.29	1.11	7 - 10
Session 2 More Mindfulness and Parenting	4	7.75	1.26	6 - 9
Session 3 Mindfulness to Increase Awareness	4	8.00	2.16	5 - 10
Session 4 Mindfulness and Acceptance	5	8.40	2.51	4 - 10
Session 5 Attachment Security	4	8.50	1.29	7 - 10
Session 6 Mindfulness for Difficult Thoughts	6	9.17	0.98	8 - 10
Session 7 Self-Evaluations and Self-Compassion	5	8.60	1.14	7 - 10
Session 8 Mindfulness of Emotions	4	9.25	1.50	7 - 10
Session 9 Mindfulness for Managing Emotions	5	9.40	0.55	9 - 10
Session 10 Emotion Acceptance	4	8.75	1.50	7 - 10
Session 11 The Good Enough Mother	6	8.50	1.52	6 - 10
Session 12 Review Parenting Goals and Program	6	9.33	0.82	8 - 10
Total	60	8.68	1.37	4 - 10

As shown in Table 62, the overall mean rating of the usefulness/relevance of session activities and discussions was 8.68, with a range of 4 – 10. The highest rated session was session 9: 'Mindfulness for managing emotions', and the lowest rated session was session 2: 'More about mindfulness and parenting' (continued introduction about mindfulness in the context of parenting), with no significant difference found between these sessions as indicated by a Wilcoxon Signed Ranks Test. This indicates that the majority of participants found all twelve sessions useful and/or relevant for their concerns.

10.1.2.2 Mindfulness for being a mother.

Participants rated how helpful they believed mindfulness would be for them as a mother on a scale from 1 (not helpful at all) to 10 (highly helpful) at the end of each session.

As shown in Table 63, the total mean helpfulness rating was 8.84 with a range of 6 - 10. The highest rating was at session 12: 'Review of parenting goals and the program', and the lowest rating was at session 2: 'More about mindfulness and parenting', with no significant difference found between these sessions. The standard deviation of ratings reduced from 1.62 at session 1 to 1.03 at session 12, with a reduction in range over time. This indicates that all participants considered mindfulness to be helpful for them as a mother and this tended to increase over the twelve sessions.

Table 63

Ratings of how helpful mindfulness will be for participants as a mother

	N	*M*	*SD*	*Range*
Session 1 Mindfulness and Parenting Introduction	7	8.57	1.62	6 - 10
Session 2 More Mindfulness and Parenting	4	8.00	1.63	6 - 10
Session 3 Mindfulness to Increase Awareness	4	8.50	1.73	6 - 10
Session 4 Mindfulness and Acceptance	5	8.60	1.14	7 - 10
Session 5 Attachment Security	4	8.50	1.73	7 - 10
Session 6 Mindfulness for Difficult Thoughts	6	9.17	1.33	7 - 10
Session 7 Self-Evaluations and Self-Compassion	5	9.00	1.41	7 - 10
Session 8 Mindfulness of Emotions	5	9.20	1.30	7 - 10
Session 9 Mindfulness for Managing Emotions	5	8.80	1.30	7 - 10
Session 10 Emotion Acceptance	4	8.50	1.29	7 - 10
Session 11 The Good Enough Mother	6	8.83	1.17	7 - 10
Session 12 Review Parenting Goals and Program	6	9.33	1.03	8 - 10
Total	61	8.84	1.28	6 - 10

10.1.2.3 Mindfulness for life in general.

Participants rated how helpful they believed mindfulness would be for them in their life generally on a scale from 1 (not helpful at all) to 10 (highly helpful).

Table 64

Ratings of how helpful mindfulness will be for participants in life generally

	N	*M*	*SD*	*Range*
Session 1 Mindfulness and Parenting Introduction	7	8.57	1.13	7 - 10
Session 2 More Mindfulness and Parenting	4	8.00	1.63	6 - 10
Session 3 Mindfulness to Increase Awareness	4	8.25	2.22	5 - 10
Session 4 Mindfulness and Acceptance	5	8.80	1.30	7 - 10
Session 5 Attachment Security	4	8.25	2.06	6 - 10
Session 6 Mindfulness for Difficult Thoughts	6	8.83	1.47	7 - 10
Session 7 Self-Evaluations and Self-Compassion	5	9.20	1.10	8 - 10
Session 8 Mindfulness of Emotions	5	9.40	0.89	8 - 10
Session 9 Mindfulness for Managing Emotions	5	8.80	1.30	7 - 10
Session 10 Emotion Acceptance	4	8.50	1.29	7 - 10
Session 11 The Good Enough Mother	6	8.83	1.17	7 - 10
Session 12 Review Parenting Goals and Program	6	9.33	1.03	8 - 10
Total	61	8.77	1.31	5 - 10

As shown in Table 64, the total mean helpfulness rating was 8.77 with a range of 5 - 10. The highest rating was at session 8: ‘Mindfulness of emotions’, and the lowest rating was at session 2: ‘More about mindfulness and parenting’, with no significant difference found between these sessions. This indicates that all participants considered mindfulness to be helpful for them in their lives generally across all twelve sessions.

10.1.2.4 Mindfulness exercises.

Participants rated how much they liked the mindfulness exercises during the sessions on a scale from 1 (not at all) to 10 (a lot). Some mindfulness exercises were repeated within groups and between groups; and some exercises that were practiced in group 1 were excluded in group 2, while other exercises were introduced in group 2. This was based on the different needs of each group. For example, group 2 participants had greater difficulty identifying and managing emotions, and tended to have greater negative self-evaluations than group 1 participants; therefore additional mindfulness of emotions and self-compassion exercises were included for group 2.

As shown in Table 65, the total mean mindfulness exercise rating was 7.35 with a range of 3 - 10. The mindfulness exercises were categorised by focus, with mean ratings ranging from 6.67 to 7.89 across the four categories, with the highest category rating found for the 'internal physical mindfulness exercises' and the lowest category rating for the 'self-compassion exercises', although the more explicit 'loving kindness self-compassion' exercise was amongst the most highly rated. Although no significant difference was found between these sessions, the mean ratings indicate that there are differences between individuals' levels of enjoyment of mindfulness exercises, yet most participants reported liking the majority of mindfulness exercises.

Table 65

Ratings of how much participants liked the mindfulness exercises

Mindfulness Exercise	*N*	*M*	*SD*	*Range*
External Mindfulness Exercises	24	7.46	1.96	3 - 10
Mindfulness of an object	7	8.43	1.81	5 - 10
Mindful listening	8	7.13	1.89	5 - 10
Mindfulness of sounds	7	7.14	1.21	5 - 8
Mindfulness of taste	2	6.50	4.95	3 - 10
Internal Physical Mindfulness Exercises	9	7.89	2.09	3 - 10
3 minute breathing space	4	8.75	0.96	8 - 10
Mindfulness of breath (body scan)	5	7.20	2.59	3 - 10
Self-Compassion Exercises	6	6.67	2.07	3 - 9
Loving kindness self-compassion	2	8.50	0.71	8 - 9
Soften soothe allow	2	5.00	2.83	3 - 7
Mindfulness of emotion in the body*	2	6.50	0.71	6 - 7
Internal Experience Mindfulness Exercises (acceptance of thoughts & emotions)	38	7.24	1.97	3 - 10
Expanding the container	5	5.40	1.82	3 - 7
Leaves on a stream	6	8.00	1.67	6 - 10
Thank you mind	8	7.50	2.07	3 - 9
Labelling thoughts and feelings	4	8.25	2.36	5 - 10
Labelling emotions	2	7.50	0.71	7 - 8
Mindfulness of emotions	8	6.63	2.20	3 - 9
Total	71	7.35	2.06	3 - 10

*Incorporates a self-compassion approach

10.2 Qualitative Results

Qualitative analysis of the program feedback questionnaires, individual interviews and focus groups revealed themes about participants' experience of the program, mechanisms of change, and suggested program changes.

10.2.1 Participants' experience of the MPG-BPD program.

The main themes that participants reported about their experience of the MPG-BPD program involved the program being different to other parenting groups, positive experiences and outcomes related to non-judgement, sharing experiences, and group facilitator factors.

Differences between the MPG-BPD program and other parenting programs.

All four participants who attended the focus groups (Kate, Fiona, Jessica, Alena) reflected on the differences between the MPG-BPD program and other parenting groups. Kate's reflection on her experience of the MPG-BPD program compared to other parenting programs indicates that the MPG-BPD program successfully addressed the particular difficulties experienced by mothers with BPD and BP traits.

> *Although I'd done parenting courses they'd all focused on airy-fairy nice things of how to deal with the behaviour of the child, rather than your own reactions, and not just containing reactions like…it was either follow this sort of formula, you know get your child back on track or whatever, because you're perfect, so really the issue is here, and you're not doing – you know it's only because you don't know what you're doing that it means that it's like that. Whereas this group didn't assume that – they assumed that it was not just that you didn't know what you were doing; it was that you were coping with something else as well. And then there's anger management courses and stuff to do with children and that's all about stopping and counting to ten and – neither of those two are*

> *really saying 'Okay it's okay to get pissed off and it's okay to be this or that', but you still sort of deal through it. They're all a bit – not quite right I guess….I'd just sit there and feel bad that everyone else was wonderful and could understand how their relationships aren't going so wonderfully and all that sort of thing. Or they're absolutely in love with their children but they just had an anger management problem. Whereas I had a lot more ambivalent feelings towards my kids altogether. I guess this didn't assume those things from the start (Kate).*

Kate further identified that the MPG-BPD program focus on the mothers' experiences and personal difficulties assisted participants in the practical development of their parenting abilities:

> *Yeah more that it was to do with the self, and how you – the reasons behind your approach to parenting, and how to best help you as a person to then be a better parent, rather than give you another toolkit that you've probably already picked up at the child centre (Kate).*

Jessica highlighted how the program eligibility criteria, in relation to the types of difficulties participants' experience, increased her comfort and willingness to attend the MPG-BPD program compared to other parenting programs.

> *There was an atmosphere of – probably most of us here who are attending it are because we've got issues and stressors in our life that not everyone has. And therefore we're a bit more understanding of the difficulties that each other have and we know that going in there rather than just any old parenting group where other people might not understand or have the same difficulties, and you don't feel like mentioning it because you don't want to freak them out or whatever. But going in I was aware that the other participants would be like me and have had some kind of issues and problems as well (Jessica).*

Jessica and Alena's discussion of differences between the MPG-BPD program and other parenting groups revealed an anticipated sense of acceptance due to the eligibility criteria, and an enjoyment of the conversational approach to skill development utilised by the MPG-BPD program.

> *Jessica: Compared to just a normal or standard mother's group where you feel a little bit guarded about what you can and can't say – whereas that wasn't an issue here because we knew that we were here because we had difficulties. Even though they weren't the same difficulties they were still – we came in knowing that it was going to be an accepting sort of atmosphere…I guess you didn't know until you'd been there for a few weeks, but I assumed it would be because I knew that if I felt really judged or uncomfortable I wouldn't be coming back!*
>
> *Alena: I felt more it was going to be a kind of – stand up, here's the board here's – initially I thought there'd be a bit of 'We're going to look at this, we're going to talk about that'. So to come in and do what we did – it was pretty awesome in its way wasn't it.*
>
> *Jessica: I agree, I agree.*

Kate and Fiona identified that feelings of shame were activated for them in other parenting programs, and highlighted the accepting and non-judgmental stance of the MPG-BPD program:

> *Kate: I wanted to be in more of an environment for parenting stuff where it was accepted that you struggle with it and that —*
>
> *Fiona: And that there's no shame.*
>
> *Kate: Yeah a lot of these parenting courses I always felt like I was the bad mum in the group.*

Sharing experiences.

All four participants identified that through sharing experiences with each other, the program resulted in an experience of connection, support, validation, and normalisation. Jessica reflected on the impact that sharing experiences had on her self-evaluations and sense of isolation:

> *I still give myself a much harder time than I would give anyone else. But somewhat lessened because I felt so supported in the group. I don't know if it was the actual mindfulness per se or just hearing other women say "Sometimes I feel stressed, overwhelmed, anxious, alone" and going "oh I'm not the only person who feels like this – look here are two or three other women who feel the same way"…That makes me feel much better about – I feel far less judgmental about myself knowing that I'm not the only person who feels that way. That I reckon – I know that those three or four other women had those feelings, which made me go "well probably there's a lot of women out there who are all feeling this, but we don't really talk about it". So I felt less alone (Jessica).*

When asked what had changed for her as a mum since attending the program, Aisyah reported:

> *I think the number one thing was being aware that I wasn't the only one who was struggling with my own circumstances – that there are other people with similar scenarios. Not causes, but similar scenarios. And that helped, because it felt more encouraging. Like being the only lonely planet in the whole universe, as opposed to being a planet amongst others (Aisyah).*

Jessica reflected on a sense of safety and support that was established in the program:

> *It was quite intense, but it was a very safe place to be able to express yourselves and everyone was really supportive. So it seemed to be really useful (Jessica).*

For Fiona, sharing in the group helped her to better understand her own reactions and normalised her experience:

> *Particularly to just be able in the group to understand that Aisyah and Kate feel similar and that that's what we do, that's one of our things, when we're triggered, we get pretty – because we've had this trauma in our lives. And it's really quite normal. I don't want that to be an excuse, but it explains it. It's not acceptable for me to behave like that, but I'm getting there (Fiona).*

Non-judgemental approach.

Five participants (Kate, Fiona, Jessica, Alena, Kylie) reflected on the non-judgemental approach of the program and how that resulted in an increased sense of support, and outcomes of increased self-acceptance and empowerment.

> *There was that sense of you could talk about things that are really bothering you and you wouldn't get disapproval, you'd get "what can you do moving forward and we still support you" and this is a valuable part of this group (Jessica).*

> *Being in that situation where we're all saying – you know some not pleasant things about ourselves at times, and it's just – not that it has to be accepted and it's not great behaviour, but that it's not judged or you don't feel that it's judged (Alena).*

Jessica reflected on how meaningful it was for her to experience a non-judgmental connection with other mothers:

> *I think in a way for me I got just as much out of when we were sitting around discussing things in general just as a group of women, was just as – almost as useful as the practical stuff that we were being taught about mindfulness. Just knowing that you could be honest about problems that you were having and not worry about people judging you for that. I think that was just as useful as the actual practical techniques and the mindfulness exercises themselves (Jessica).*

The following quotes illustrate how significant the non-judgemental stance of the MPG-BPD program was for these mothers with a trauma history:

> *To be able to just be in a group where you can share those horrible feelings that you have and know that – well it is probably quite normal, but it's even more normal for people who've had trauma in their earlier life. That was just invaluable for me, and gave me a great sense of accepting myself (Fiona).*

> *I think the group's just given me self-empowerment, and that I could come in and talk about anything and wouldn't get judged, and could be honest, and yeah. And being able to do that's given me back some of the power that was taken (Kylie).*

Kylie further highlighted the benefits that this non-judgemental stance had for mothers experiencing difficulties associated with BPD.

> *I think it's very helpful. I just don't think anyone realised when you go in there that it's going to be as therapeutic as what it is. That it's very good to have somewhere to go where you can be open and honest, especially about being a mother, and know that they're not going to judge you saying "I'm having a hard time" or "I did this wrong" or "I did this wrong". And no one's going to judge you and they support you (Kylie).*

Although the participants did not explicitly state that their sense of shame related to their experience of being a mother had decreased, this was implied in their quotes and seems to be related to the experience of support, non-judgement, normalisation, increased self-acceptance and improved self-evaluation.

Program facilitators.

The four participants who attended the focus group reflected on the range of life experiences and perspectives of the facilitators and how this added to their positive experience of the program. The program was conducted by three female facilitators, with both groups facilitated by the clinical psychologist who had children and grandchildren and the provisional psychologist who did not have children. The third facilitator of the first group was a provisional psychologist with three children, and in the second group the third facilitator was a registered psychologist with two children.

> *I think that was really good having someone from perhaps an older generation who's actually a grandma, and then (facilitator) who doesn't have kids of her own, and they're two very fresh perspectives there, which I thought was a really good thing. So yeah generally speaking as a unit the facilitators work really well together and really good (Jessica).*

> *I did enjoy the different directions, and the different age groups and the different stages in life. I found that really good actually (Fiona).*

Kate considered it important that at least one program facilitator had experienced being a parent:

> *I feel like there'd have to be someone with children or who'd been through having children, at least, in the mix (Kate).*

Kate and Alena reflected on how the appropriate disclosure of facilitators' own experiences established a sense of equality between the facilitators and participants:

> *It wasn't an 'us and them' sort of situation as such, it was – people all shared. And I think that was a great thing with the facilitators as well. You all gave that bit of your humanity to the whole situation as well (Kate).*

We're coming to a place where there are people that think like you. Even you guys were putting your experiences in and just the support, it was really useful (Alena).

Although the program manual (Appendix B) guided the structure of the sessions, facilitators were flexible with allowing discussions to continue when it seemed clinically appropriate. Facilitators recognised that some individuals needed further discussion in order to clarify concepts and work through areas of difficulty with the support of the group. Kate explicitly identified this as a positive aspect of the program:

Well letting the group flow for a while, that's quite good. If the group gets onto a topic, and it seems within the realms of appropriateness – I know that quite often we got to topics that you guys weren't ready for yet, but we seemed to just naturally find ourselves there. And quite often you were willing to just go with that. But if we were to get too far off topic, somebody stepping in and saying "Okay we need to actually get through this and this" – I guess that's good (Kate).

Jessica described the facilitator flexibility in relation to participants' contributions during sessions as positive and supportive:

[The facilitators] were all very patient with us because as women who aren't necessarily having an easy time of things there might have been times when we were calling in sick or not able to contribute as much. I know there was one or two sessions where I was feeling overwhelmed and I sat back and I really didn't say very much and I couldn't really contribute much. But I didn't feel like there was any negative repercussions for that, it was sort of like "Well you're having a bit of a difficult day", then you sit back and maybe listen more than you actually talk today, that's fine (Jessica).

10.2.2 Mechanisms of change.

Participants' identified several mechanisms of change, with the main themes of: 'the good enough mother', attachment theory, reflection on own childhood experiences, self-compassion, mindfulness and mindfulness practice.

Good enough mother.

Five participants (Kate, Fiona, Jessica, Alena, Kylie) explicitly referred to the 'good enough mother' concept as being useful for changing their perceptions of themselves as mothers. Kate found this concept related to "acceptance of self", while Jessica associated it with "self-compassion". The following quote illustrates the impact of this concept for Kylie:

> *What really stuck was the ideal mother and the good enough mother and that's, most days it goes through my head at least once or twice that it, it wasn't a concept that I'd thought of before the group because it wasn't something that I've really sort of thought about and then when we went through it in the group and I thought about it once I got home and it was, well, they really are in my head intertwined and tuck together and the more I try and work with that, the lesser, the further apart they become and the good enough mother doesn't have to be the perfect mother (Kylie).*

Attachment theory.

When asked what program content was most helpful, four participants (Kate, Fiona, Jessica, Alena) identified attachment theory using the COS model as an important concept that helped them to recognise their children's attachment needs. Alena found the COS model was "improving my understanding of (daughter)'s needs". Kate found the repairing relationships concept to be helpful for interrupting her automatic reactions and increasing her parental reflective functioning:

> *I think the biggest thing I took out of that was the repair thing, and to know that I will screw up, and that instead of getting guilty and just continuing that little part of the cycle I could actually sort of break in and repair…I could start again, and yeah stuff it up again, but still keep doing that. And the more that I kept thinking of that, the more I could stop and actually start to think of what's going on in his head (Kate).*

Kylie identified "(Almost) everything I need to know about being a parent in 25 words or less", a COS handout, as a simple and helpful resource for keeping her child's attachment needs in mind. Fiona reflected on how the COS model helped her to understand where her needs had not been met in childhood and allowed her to develop her capacity to address her children's needs:

> *Reflecting back on the lack of that, that I'd had, with the attachment with my own mother. That was a revelation…I remember writing down all of the things that she didn't do…like I didn't feel this cherished, and that diagram – that really struck a – you know the way when – delighted, I didn't feel like my parents delighted in me one bit…That really that brought home how they were lacking in my life but how I could – and not just go through the motions, because before I think I was just going through the motions sometimes, turning up at the concert and being proud of them. But now maybe that's coming a lot more easier, you know, to be genuinely proud of them (Fiona).*

Reflection on family of origin.

Three participants (Fiona, Aisyah, Daria) emphasised the significance of reflecting on their own childhood experiences within their family of origin. They reported that this resulted in an improved understanding of their own parenting styles and emotional experiences, as well as increased acceptance.

I think that sort of changed my thinking, by being in the group, it's kind of changed my perception of how the world really works. It doesn't always work the way you want it to work...I think, yeah it's more the acceptance that I will not have the family that I want. So my immediate family is now my family (Aisyah).

I learned – the main thing – going back to the family of origin and how emotion was dealt with – that was huge...So that's been absolutely huge, and when I think back to – as I said before, I wasn't even allowed to be happy at home. I mean I'm really quite serious – so I make more of an effort now to have fun. I work, I decide to show my sense of humour more...I'm allowing myself to be seen to have a good time (Fiona).

Fiona and Daria reported that by addressing their family of origin in the program, they were able to process unresolved childhood experiences, resulting in an improved emotional experience and an increased acceptance of their past.

Brought up unresolved feelings and made me grieve and face them and eventually move through them (Fiona).

The willingness to deal with the issues that I had with my mother's parenting, probably was one of the biggest hurdles, because I was avoiding thinking about that. So by coming to the course, it meant that I had to then address that. And then deal with that I wasn't happy that I didn't meet her till I was fourteen. And so okay there's nothing that I could have done to change that fact. But had I not actually thought about the reason why I didn't want to address it, her parenting to me or the lack of her parenting…But until I actually thought about that parenting and the questions, the realisation was that there's nothing I could have done to affect the choices, so there was no real guilt or embarrassment of dealing with that, and that's the whole reason I was avoiding analysing that situation or that relationship, was because of those reasons but I couldn't have worked that out unless I did analyse it. So I was avoiding it like the plague, but without this course I wouldn't have been forced to address it. And even just –

"hang on let's think about why you don't want to think about your mum's parenting to you, or lack of your mother's parenting". Well I hadn't even dealt with that before the course, and you know I'm a forty-odd-year-old woman who's never even thought about or has avoided to think about her mother's parenting…and yeah it put a lot of skeletons to rest for me (Daria).

Mindfulness.

All seven participants found several aspects of mindfulness to be helpful, with the repeated practice helping to increase their mindfulness abilities.

I understood the theory, but really had the chance to practise it [in the program] (Jessica).

Having the mindfulness practice every class – that was really helpful especially because I struggle to do it at home (Kylie).

Acceptance appears to have been a component of mindfulness that had a positive impact on participants' view of self and reactivity. This is portrayed by the participants' responses when asked what they considered to be the most helpful program content:

Acceptance theory (Jessica).

The concept of accepting yourself as you are (Kate).

Sharing and discussing views on acceptance and being mindful of now (Aisyah).

It's not how it 'should be', but 'it is as it is' (Kylie).

Mindfulness of thoughts and emotions were also identified as one of the most useful components of the program. Aisyah found "discussing about our thoughts and its ability to take over" was most helpful for her. Kylie noticed that "what stuck with me" was a mindfulness of thoughts exercise:

> *The one about the leaves floating on a river and not getting stuck in one particular leaf, letting them just float past you, which really helps at night time with the thoughts (Kylie).*

Participants' appeared to find the focus on emotions and applying mindfulness to emotions quite challenging during the program, although the following responses when asked about the most helpful program content indicates that this was an important component of the program:

> *Talking about emotions (Kylie).*
>
> *Introduction to emotions (Alena).*
>
> *Learning about emotions (Fiona).*
>
> *Mindfulness for managing emotions (Jessica).*

Self-compassion.

Some participants described self-compassion as a meaningful concept that resulted in positive change. Jessica reported that mindfulness and developing an alternative perspective of her own problems resulted in increased self-compassion:

> *I find it a lot more easy to be supportive and accepting to other people, whereas on myself I'm much tougher and don't give myself as much compassion as I would give to someone else. So I think that's something that doing mindfulness*

on your own, and actually going no well look if whoever said something – had that problem in the group – then you'd be supportive, and you'd say this that and the other. So you need to be able to find a way to be supportive of yourself and not just constantly criticise yourself because that's not really useful. It doesn't go with being mindful. So mindfulness is sort of – there's more things come up other than things we've directly talked about, like mindfulness is something I've noticed is being a little bit easier on yourself and not so critical of yourself. That seems to be something that's come out of the mindfulness (Jessica).

Alena described how the concept of self-compassion allowed her to do more positive things for herself, feel grounded and experience less guilt:

One of the things that I gathered, this was the self-compassion thing where I don't have to feel guilty all the time. And I'm just feeling less guilt in what I'm doing. So I'm giving myself some treats, which is unusual. Slowly getting things done, still finding time for me, the guilt's gone – I don't know how to explain all that but just feeling calm and grounded a bit more than – it's not all day every day, but it's more than I've ever had (Alena).

10.2.3 Suggested changes and extensions to the program.

The four participants who attended the focus groups and completed the post-program feedback questionnaires (Kate, Fiona, Jessica, Alena) contributed suggestions for program improvement.

Program Length.

All four participants suggested either increasing the number of sessions in the program or the length of sessions. Participants felt that twelve sessions of two hours duration (including a break) did not allow enough time to have detailed discussions about participants' individual experiences, and thoroughly cover session content.

It would have been perfect if it was a year-long thing or something that went for twenty-four weeks instead of twelve. That we could have gone into stuff in much more detail, much more in-depth (Jessica).

Sometimes I feel that I didn't say enough, that I was getting all this support where I hadn't actually told the full story because you didn't want to get into that because it would be taking up too much time. I thought this is enough – you know, but I think sometimes I'm much worse than that, I really need to give an example of this very bad experience or whatever and then get feedback from that. But you think 'oh there's just no time for that' (Alena).

Jessica and Alena also raised the importance of the development of trust and safety over time:

Jessica: I felt like here if I had a little bit of an overly emotional moment, I would be supported and not made to feel 'oh my god she's freaking me out', sort of thing. So I think that would only have gotten better over time, I think. Like the ability to trust.

Alena: Just that continuity of it. I don't think we're left to fend for ourselves, I'm feeling quite – three months and I'm feeling quite optimistic and I'm wanting to continue, but yeah you feel safer, you'd feel safer over a year.

Following a discussion of practical issues that could arise with a longer program (e.g., funding limitations, a lengthy program might be off-putting), an alternative suggestion of lengthier sessions was proposed:

Sometimes I felt that the sessions could go longer, depending on the topic some felt like they needed more time. Simply because they got everyone involved and contributing, and I wanted to hear more at times (Alena).

Kate: Maybe three-hour sessions with your break in the middle.

Fiona: Yeah that sounds quite substantial.

Alena: Maybe it stays at three months and they're day sessions. Or half a day, you know like three to whatever hours?

Jessica: Three hours maybe, more than that would have been hard for me.

Alena: Probably, two hours isn't enough.

Jessica: Yeah I can imagine doing three hours with a break, but more than that we'd probably start to wear down a little bit.

When the facilitator enquired about participants' opinions regarding booster sessions, all four responded positively and contributed suggestions about frequency and content.

Alena: Like a monthly thing maybe?

Jessica: Yeah a monthly thing like a booster shot.

Alena: Like where are they now? [Laughter]

Alena: It's great to think you might come back and have really good news every time you come back. Gives you something to work towards even more, doesn't it?

Jessica: Yeah I would definitely be interested in that.

Alena: Once a month till the end of the year or something?

Jessica: So for another six months, once a month.

Kate and Fiona discussed the idea of an ongoing group which all participants who completed a MPG-BPD program could join:

> *Kate: Yeah once every three months would be cool. And I know this other group – what happens is even though it becomes a monthly group, all the other people who have done the group filter into that group so it's not just – so it's like a support network in that sort of way. So you're coming monthly but you're meeting new people in the group.*
>
> *Fiona: And you're connecting and sharing and learning from – that sounds really good.*

All four suggested that booster sessions could be used to reflect on participants' progress and difficulties:

> *Jessica: I guess maybe how we're progressing.*
>
> *Alena: It gives you something to look towards, and think 'Where can I be by the time' – even in the next month. Or maybe they should be every three months, I don't know. Maybe once every three months for the next year, so four.*
>
> *Kate: Just to see how you're tracking and what things might have come up that weren't maybe covered or things that you still have difficulties with.*
>
> *Fiona: A little synopsis of how your three months have gone, with – you've got your timer, you've all got five minutes to say 'I found this difficult', or 'I recognized I changed when this happened' – share your successes and your – any insights you gained.*

Group size.

All four felt that the small group size contributed to their positive program experience, as it allowed all participants to be involved in group discussions and an individualised focus.

> *I actually thought at first this was too few, and that would be in itself intimidating. But in order for people to actually all be able to talk…I wouldn't have thought much more than double what we had would be…six would probably be ideal (Kate).*

> *Jessica: It did end up being quite a small group. I think that was probably good that it was a smaller group.*

> *Alena: Yeah well we're talking about having extra time now and there were generally only three of us, and we felt like we needed more time, so imagine a bigger group. Keep it small.*

Individualised support.

All four participants felt that it would be useful to have a form of individual support available to supplement the program. Fiona suggested "debriefing after intense sessions" and reflected that:

> *There were some times where I needed to debrief and I wanted to come back in and – I think a couple of times I would have come in and talked for twenty minutes about something that was really bothering me because I hadn't really dealt with it (Fiona).*

Alena made a similar suggestion:

> *The only thing I would do, if you want to call it doing it differently, is at the end of the session I would like to just offer if people wanted to stay or not (Alena).*

Kate received individual support from the clinical psychologist during and after the program due to suicidality that was triggered by aspects of the program, and reflected:

> *I think having that backup support of (clinical psychologist) has helped. And having that ongoing (Kate).*

Although Jessica was receiving counselling at the time of the program, she felt that having individual time with a facilitator would have guided her with following up on difficulties with her psychologist after the program.

> *I think what I would have liked to have had would have been…some one-on-one time to be able to say look these are some of the things that have come up that I'm dealing with now, even though the group's finished...and they'd be able to go 'okay well you need to speak to your counsellor about x y and z'…you might be able to give us some - or help us work out what the particular problems are that we can then take to the psych (Jessica).*

Readings and handouts.

Three participants (Fiona, Jessica, Alena) felt that more time could have been spent thoroughly discussing the readings and handouts during sessions.

> *You don't want to give us homework as such, but whether we could have discussed them, as in 'please read this, we'll come back, we'll have a bit of chat about it, what did you think?' And it might have – again a bit of accountability. Because I did read them, but I was allowed to forget if I wanted to – and it might have helped it sink in a little bit better, or was there anything that didn't make sense to you, or that – maybe you're reading it wrong, am I interpreting it wrong…I think there were periods where we ran out of time…You didn't get to go through them and understand what they were really all about (Jessica).*

Jessica also suggested that facilitators could provide guidance about the important components of the content to focus on:

> *Summarise them, and say this is what we actually want you to know, this is what we want you to learn, but here's the guts of it here in short sweet terms (Jessica).*

Children's age groups.

Kate and Fiona proposed separate groups for mothers with children at different developmental stages:

> *Fiona: I think the course could probably operate for the younger but maybe different for the older, the pre-teens? There would have to be some differences.*
>
> *Kate: Separate groups or something.*
>
> *Fiona: Yeah…Well there's probably two distinct groups, the younger ones and then the pre-teens maybe? When they've had a few years at school, when their parents would be receiving feedback from maybe teachers as well, they might have had a bit of a break because they're back at work, or the children are actually at school, so they might have had a bit of time to get a bigger picture.*

Childcare.

Kate and Fiona discussed a lack of childcare options as a barrier to participation in the MPG-BPD program, particularly for mothers' with pre-school children. Fiona highlighted an important point about the program's target population:

> *Quite possibly the mum's you'd be attracting won't have that family support, because that's part of the problem (Fiona).*

Kate indicated that it would be easier for mothers if the MPG-BPD program offered a childcare option:

> *If you could bring your kids and know that they were going to get looked after for two or three hours while you do this (Kate).*

A lack of childcare support was indeed found to be a barrier during program recruitment, as several potential participants were unable to attend the program without the provision of childcare.

In summary, all participants who provided evaluation feedback indicated that the MPG-BPD program could be improved by increasing the duration of the program and/or sessions, offering booster sessions and some form of individual support to participants. Additional suggestions were made regarding the understanding of content, children's ages, and program accessibility.

Chapter 11: Discussion

The aim of this thesis was to develop and evaluate a mindfulness-based parenting group program for mothers with BPD traits. The program aimed to promote positive changes in parenting and parent-child relationships, improve mindfulness, general psychological functioning, and BPD symptoms and deficits including reflective functioning and emotion regulation. This thesis argued that by incorporating aspects of BPD-treatments and parenting interventions, an intervention program could be developed that successfully addresses BPD-specific parenting issues experienced by mothers. The 'Mindful Parenting Group Intervention for Mothers with Borderline Personality Disorder Traits' (MPG-BPD) was an integrated approach informed by DBT, MBT, ACT, attachment-based parenting, and mindful parenting. The current study provided a mixed-method evaluation of the MPG-BPD program. In order to provide a comprehensive evaluation of the MPG-BPD program, first the qualitative pre-program findings are discussed, followed by the quantitative and qualitative program outcomes, and then the program evaluation findings. These findings are considered in light of previous research, theory, and recommendations for interventions targeted at mothers with BPD. Finally, an overview of the main outcomes of the present study is presented, then the study implications, difficulties and limitations, strengths, and possible directions for future research.

11.1 Pre-Program Findings

Qualitative analysis prior to the MPG-BPD program revealed three core themes in the participants' experience of being a mother; these included the significance of love as a positive aspect of being a mother, negative emotional reactivity, and a sense of

shame. The common experience of shame appears to be a result of negative self-evaluations and feelings of guilt about their parenting difficulties and BPD symptomatology, such as emotional reactivity and anger outbursts. This finding supports studies that indicate shame as a core emotion in BPD and that a shame-prone self-concept may be especially pertinent for women with BPD features (Crowe, 2004; Hawes, et al., 2013; Rüsch, et al., 2007). These findings demonstrate that the current study participants were experiencing high levels of self-criticism and shame, and provide support for the inclusion of compassion as a program component (Gilbert, 2000, 2010).

An exploration into the mothers' childhood experiences of parenting revealed a common theme of little affection received from parents described as disengaged, authoritarian, absent, or overly critical. This is consistent with international research findings where individuals with BPD report parental rearing patterns that involve greater parental control, punishment and rejection, and less emotional warmth, maternal affection, and care compared to individuals without BPD (Huang et al., 2014; Paris, Zweig-Frank, & Guzder, 1994; Torgersen & Alnæs, 1992; Zweig-Frank & Paris, 1991). It is therefore not surprising that parental emotional neglect and the absence of an adult attachment figure are strong predictors of BPD (Sabo, 1997). Consistent with previous studies associating insecure attachment styles with BPD and BPD traits (Agrawal, et al., 2004; Bateman & Fonagy, 2004; Levy, 2005), participants of the current study identified with insecure attachment styles prior to the MPG-BPD program.

11.2 Program Outcomes

The current pilot group program resulted in a range of positive outcomes for the mothers and for the mother-child relationships. It is theorised that these improvements will subsequently result in improved outcomes for their children.

11.2.1 Changes in the experience of being a mother.

The results of the qualitative analysis following participation in the MPG-BPD program revealed three core changes to the participants' experience of being a mother. These changes included increased reflective functioning, improved self-concept, and increased self-care.

Increased reflective functioning.

Participants described increased reflective functioning as a program outcome that continued to develop and be maintained six-months after program completion. The mothers' found that they were increasingly self-reflective and, concurrently more reflective about their children's mental states. This seemed related to an increased awareness of their child's experience that developed from having a greater interest and curiosity in their child's mental states, and an improved mindfulness capacity. This ability to reflect on internal mental states appears to result in a greater understanding of self and others alongside the consideration of others' perspectives. As attachment-based interventions have been found to result in increased parental reflective functioning (Suchman, et al., 2010), the current study's finding provides further support for the theoretical notion that increasing mentalization capacity may be of particular value to address reflective functioning deficits within an attachment relationship for BPD (Fonagy & Bateman, 2006).

Although the qualitative interviews demonstrated increased reflective functioning as a program outcome, Wilcoxon Signed Ranks Tests revealed that the quantitative hypothesis predicting significantly increased self-reported levels of parental reflective functioning was only supported for the interest and curiosity dimension of parental reflective functioning. Considering this increase occurred between program completion and the six-month follow-up, as measured by the PRFQ, it may indicate that the MPG-BPD program is a catalyst for the development of awareness that mental states underlie behaviour and curiosity about these mental states within the parent-child relationship. As the validity of the PRFQ has only been assessed for parents of children aged 0-5 years (Luyten, et al., 2014), these findings indicate that there may be different processes and abilities involved in parental mentalization with older children (Luyten, Fonagy, Lowyck, & Vermote, 2012). Wilcoxon Signed Ranks Tests on individual PRFQ scores found Kate to be the only participant with an immediate significant increase in mentalizing post-program, which might relate to the significant reduction in her initial high level of BPD symptom severity after participating in the MPG-BPD program.

Although it has not yet been clearly established that MBT results in increased reflective functioning capacity (Bateman & Fonagy, 2013), reflective parenting programs such as Minding the Baby (Sadler, et al., 2013) demonstrate significant increases in parental reflective functioning by interview measures. This is consistent with the present finding of qualitatively increased reflective functioning as a program outcome, which is extended by the quantitative increase in the interest and curiosity dimension of parental reflective functioning. These findings are thought to result from the reflective stance modelled by facilitators combined with, reflection on participants' own childhood experiences and an increased awareness of their child's needs. This may

result in participants' children having improved developmental outcomes, especially considering the supporting evidence for the fundamental role a parent's ability to understand their own and their child's mental states has on the development of the child's self-regulation abilities and establishment of positive relationships (Fonagy, et al., 2002; Slade, 2006).

Improved self-concept.

The participants described improved self-evaluations following the MPG-BPD program, particularly in relation to how they perceived themselves as mothers. This program outcome appeared to be strengthened and maintained six-months after program completion. Wilcoxon Signed Ranks Tests on PSI lack of competence subscale scores demonstrated non-significant trends of all participants developing a greater sense of competence in their parenting role following the MPG-BPD program, with the majority of mothers reporting a greater sense of confidence in their parenting. On completion of the program, Jessica felt less overwhelmed by her parenting responsibilities and Kylie discovered that she had more belief in herself as a mother. The most frequently reported changes in self-concept included a reduction in self-criticism and an increase in self-efficacy, which were associated with increased reflective functioning and parenting self-confidence. These improvements in self-evaluation and self-concept may have been accompanied by reductions in shame, although shame was not directly assessed, as a strong association between self-concept and shame has been found in women with BPD, with a significant negative relationship found between a shame-prone self-concept and self-esteem (Rüsch, et al., 2007).

Participants recounted that sharing their experiences with other mothers facilitated self-acceptance, which has been found to be a contributing factor for

increased parental satisfaction and reduced parental negative emotions (Gavita 2011a), and the consequential development of functional/healthy parental reactions (Gavita, DiGiuseppe, & David, 2013). It is likely that this related to participants developing a more realistic view of themselves as mothers, in the context of the 'good enough mother', during the program and over the following six months.

These findings reflect those of a three-month inpatient DBT program for female BPD patients, which resulted in enhanced self-concept clarity including self-esteem, self-regard, social skills and confidence (Roepke, Schröder-Abé, et al., 2011). The authors argued that as self-concept clarity overlaps with the construct of identity (Campbell, Trapnell, Heine, & Katz, 1996), their results suggest that DBT may have affected aspects of the identity disturbance criterion of BPD. This indicates that the improvements to self-concept reported in the present study may also affect participants' BPD symptomatology and result in identity disturbance reductions.

Increased self-care.

Following the program, the mothers described a greater tendency for self-care, which is likely to have resulted from learning self-care skills and the program emphasis on the purpose of these in the context of participants own mental health and capacity to respond to their child. This resulted in participants making a conscious decision to be self-nurturing when experiencing distress or low mood and a growing propensity for self-compassion. By having an increased awareness of her emotions, Alena was able to identify when she was feeling overwhelmed, and rather than ignoring that sensation, she would choose to make the effort to care for herself. For Kate, as she became more aware of her experience of low mood, she chose to manage this with self-care instead of getting caught up in the mood. She also noticed that this improved ability to manage

emotions resulted in fewer low moods. These qualitative findings are consistent with the reported parental outcome of an increased ability for self-care following a mindful parenting training course (Bögels, et al., 2014), and demonstrates the utility of mindfulness for increasing parental self-care.

At the MPG-BPD six-month follow-up, self-compassion emerged as a major theme for participants, encompassing aspects of self-care, self-nurturing, and kindness to self. This suggests that it can take time for mothers with BPD traits to develop a compassionate stance towards themselves following the MPG-BPD program. These findings reflect those of CFT and group CFT for PDs, which include reductions in self-criticism, self-hatred and shame (Gilbert & Procter, 2006; Judge, Cleghorn, McEwan, & Gilbert, 2012; Lucre & Corten, 2013). The current study provides further support for Gilbert's (2000, 2010) argument for the value of compassion for individuals experiencing high levels of self-criticism and shame, which is a frequent experience for women with BPD. Additionally, considering previous research findings that have associated self-compassion with feelings of social connection, healthier interpersonal relationships, and improved emotion regulation strategies (Diedrich, Grant, Hofmann, Hiller, & Berking, 2014; Galhardo, Cunha, Pinto-Gouveia, & Matos, 2013; Kelly, Carter, & Borairi, 2014; Warren, 2015), this aspect of the MPG-BPD program may have enhanced these outcomes. As the present study implicates self-compassion as a contributing factor in a range of participant improvements, these findings provide further support for the positive outcomes of self-compassion and indicate the value of incorporating compassion in interventions for mothers with BPD traits.

11.2.2 Changes in the mother-child relationship.

Improved mother-child relationships were described by participants and seem to be associated with a change in parenting interactions where mothers increasingly attended to their children's attachment needs. Aisyah became more aware of her children's needs by reflecting on her own unmet childhood attachment needs, which motivated her to meet those needs in her own children. For Alena, this resulted in a changed mental representation of her daughter, where she came to perceive her as a "person", which resulted in Alena behaving more positively towards her, and in her daughter having more trust in her mother. As poor reflective functioning has a negative impact on the parent-child relationship (Fonagy, et al., 2002), the increased reflective functioning capacity of these mothers, particularly in regard to the interest and curiosity in their children's mental states, may contribute to the improved relationship interactions with their children. The participants' increased awareness of their children's needs is likely to be an outcome of the MPG-BPD program's mindfulness focus, alongside attachment psychoeducation and promotion of reflective functioning. These changes appear to have resulted in improved communication between mother and child, with this communication becoming increasingly meaningful. The relationship with their children became more enjoyable for the mothers as they lessened the demand placed on themselves as mothers, with a consequent reduction in role restriction. These outcomes reflect the parent-child relationship improvements reported by parents following mindful parenting interventions (Bögels, et al., 2008; Singh, et al., 2007; Singh, et al., 2006; Singh, Singh, et al., 2010) and attachment-based interventions such as WWW (Cohen, et al., 1999). As inappropriate or inconsistent mother-child interactions mediate the transmission of borderline symptoms (Reinelt, et al., 2013),

these program outcomes may reduce the risk of participants' children developing BPD traits.

11.2.3 Changes in mindfulness.

Consistent with the qualitative findings, Wilcoxon Signed Ranks Tests supported the quantitative hypothesis that predicted participation in the MPG-BPD program would result in significantly increased mindfulness skills was supported for overall mindfulness and the facets of observing, describing, acting with awareness and non-reactivity to inner experience, as measured by the FFMQ. The program's mindfulness focus with the continual practice of mindfulness exercises in and out of sessions, and the participants' application of mindfulness skills in the 'real world' resulted in the mothers' adopting a more mindful approach towards themselves and to parenting. The key changes identified were increased awareness and acceptance, with further increases in acceptance conveyed six months after the program. This suggests that while increased awareness is an immediate outcome of the MPG-BPD program, as found for BPD patients in intensive DBT (Nicastro, et al., 2010), acceptance takes time to develop and is linked to self-compassion and continued mindfulness practice. These findings are consistent with Teasdale et al.'s (2002; 2001) proposition that mindfulness-based interventions can effectively result in significantly increased metacognition and emotional awareness, where thoughts and emotions are conceptualised as mental events rather than objective reflections of reality. The increased acceptance reported by the mothers at six-month follow-up indicates that the MPG-BPD 12-session program may potentially reflect the significantly increased accepting without judgement abilities demonstrated by BPD outpatients after one year of standard DBT (Perroud, et al., 2012). The mindfulness outcomes of the MPG-BPD program provide further support

for the benefits of mindful parenting interventions and expand the application of this approach to mothers with BPD.

11.2.4 Changes in mood and emotions.

Participants' described increased affective stability as a program outcome and this appeared to be maintained six months after program completion. The mothers associated this with improvements in their emotion regulation and reactivity. Wilcoxon Signed Ranks Tests supported the quantitative hypothesis that participation in the MPG-BPD program would result in significantly increased self-reported emotion regulation abilities was supported. The significant improvements in the mothers' responses to emotions indicated by the DERS occurred in their ability to access emotion regulation strategies perceived as effective, allowing for a response to negative emotions that entailed a greater engagement in goal-directed behaviours and increased control over impulsive behaviours. This is a likely outcome of the emotion management component of the program, which focused on the identification, reflection on and acceptance of emotions. The participants' awareness of emotions appears to have developed over the course of the program and the following six months, as a significant improvement was found at the six-month follow-up. This indicates that like the growth in awareness and curiosity of mental states in parental reflective functioning, the MPG-BPD program may be a catalyst for the ongoing development of emotion awareness. The significant reduction in emotional reactivity, as measured by the DSI, found at the six-month follow-up suggests that this aspect of emotion regulation develops over time as another program outcome. These findings may relate to the maintained improvement in behavioural impulse control when experiencing negative emotions and overall emotion regulation six months after program completion. This suggests that for mothers with

BPD, the MPG-BPD program advances participants' emotion regulation skills, which continue to develop over time, and influence emotion management abilities and potentially impact on the affective stability, impulsivity and anger criteria of BPD.

Alongside the increases in mindfulness, these program outcomes seem to result in less impulsive reactions to triggering emotions. This aligns with DBT outcomes for BPD participants including decreased amygdala activity/activation, and improvements in experiential avoidance, emotion regulation and strategy (including general emotional control, and anger control and expression) (Goodman et al., 2014; Linehan, 1993a; Neacsiu, Lungu, Harned, Rizvi, & Linehan, 2014). Correspondingly, ACT interventions for BPD have resulted in improvements in emotion regulation, experiential avoidance, mindfulness, fear of emotion, and hopelessness (Gratz & Gunderson, 2006; Morton, et al., 2012). The emotion regulation improvements found in the current study are consistent with those of DBT, ACT, and research findings in which mindfulness was positively associated with emotion awareness and negatively associated with emotion dysregulation and emotional reactivity (Hill & Updegraff, 2012).

The participants identified experiencing less severe moods and emotions following the program, and the prediction that participation in the MPG-BPD program would result in significantly reduced self-reported levels of depression and stress was supported by Wilcoxon Signed Ranks Tests of group DASS scores. Additionally, post-program levels of depression were maintained six months after program completion. It is notable that this outcome of the MPG-BPD 12-session program is consistent with the significant reductions found in depressive symptoms following the lengthier interventions of MBT (Bateman & Fonagy, 1999; Bateman & Fonagy, 2009) and DBT

for BPD (Bohus et al., 2004; Koons, et al., 2001; Kroger et al., 2006; Roepke, Schröder-Abé, et al., 2011). These MPG-BPD program outcomes are noteworthy considering that no significant improvements were found for depressive or stress symptoms using the DASS measure following the 12-session ACT intervention for BPD (Morton, et al., 2012).

Wilcoxon Signed Ranks Tests of the DASS and PSI did not support predictions that participation in the MPG-BPD program would result in significantly reduced self-reported levels of anxiety and parenting stress, despite participant reports of reduced anxiety in their parenting. These finding are in contrast to the significant reductions in anxiety found as a result of DBT (Bohus, et al., 2004), MBT (Bateman & Fonagy, 1999) and ACT (Morton, et al., 2012) interventions for BPD. However, no significant change in anxiety has been found following a DBT intervention for female veterans with BPD (Koons, et al., 2001). This finding in the present study may be accounted for by the participants' baseline level of anxiety being at a lower level than was the case in other studies. For example, the pre-program DASS anxiety scores (*Mdn* = 8) were low compared to those of the ACT intervention for BPD (*M* = 23) (Morton, et al., 2012). This may be due to the MPG-BPD sample including participants with subthreshold levels of BPD symptoms.

The mothers' experience of guilt about parenting, as indicated by the qualitative analysis, notably decreased after participation in the MPG-BPD program and the mothers' associated this with increased emotion management, self-compassion, and acceptance. This may be explained by increases in mindfulness, as mindfulness has been negatively associated with lability of a range of emotions including anger, rage, sadness, depression, fear, guilt, and shame (Hill & Updegraff, 2012). Additionally, this

reduction in guilt may have been affected by participant improvements in self-acceptance, self-evaluation, emotion regulation, and mother-child relationships.

Affective stability improvements appear to be an outcome of the successful use of mindfulness for managing emotions, as indicated by increases in the acting with awareness facet of mindfulness and decreases in the reactivity to inner experience facet. Participants successfully utilised mindfulness when faced with strong or difficult emotions, which then helped them to feel more capable of managing their emotions and be less overwhelmed by them. These findings indicate that mindfulness facilitated adaptive emotion regulation strategies and consequently improved the mothers' affective stability via the MPG-BPD program.

11.2.5 Changes to BPD symptomatology.

The results of the qualitative analysis revealed several changes in the mothers' BPD symptomatology as a result of participating in the MPG-BPD program. These included improved interpersonal relationships, reduced impulsivity, and increased affective stability incorporating reduced mood reactivity and increased control over anger. Consistent with these qualitative findings, the quantitative hypothesis that participation in the MPG-BPD program would result in significantly reduced self-reported levels of BPD symptom severity was supported by the Wilcoxon Signed Ranks Tests of the PDQ-4+ measure, and these levels had decreased further six months after program completion. However, the BEST measure did not result in a significant improvement for the group as a whole. Individually, the BEST measure also demonstrated significant reductions in BPD symptom severity for the majority of participants. Notably, the most significant BEST changes were in thoughts and feelings associated with BPD (encompassing mood reactivity, identity disturbance, unstable

relationships, anger, abandonment fears, paranoia, emptiness, and suicidal thinking) than for negative or positive behaviours associated with BPD.

While the ACT intervention for BPD (Morton, et al., 2012) resulted in significant improvements as assessed by the BEST, in overall BPD symptoms, thoughts and feelings associated with BPD, and negative behaviours associated with BPD, it may be that the lack of a significant overall effect is again due to floor effects and the inclusion of participants with subthreshold levels of BPD symptoms. For example, the pre-program composite BEST scores (*Mdn* = 33) were low compared to those of the ACT intervention (*M* = 45). The finding that the two participants in the present study with the highest initial BEST symptom severity ratings (Kate and Kylie) also had the most significant reductions in these BPD features after program participation supports this inference.

The current findings are consistent with those of MBT for BPD, which has demonstrated outcomes including improved interpersonal functioning, impulsivity, borderline symptomatology and diagnostic status (Bales, et al., 2012; Bateman & Fonagy, 2008a). The reductions in impulsivity and substance use found in the current study suggests that the level of exposure to parental substance use and suicide attempts experienced by children of BPD mothers (Weiss, et al., 1996) may be lessened by participation in the MPG-BPD program. Additionally, considering Barnow et al.'s (2013) finding that BPD features in children are predicted by maternal self-rated BPD symptoms, these reductions in BPD symptomatology may indicate a reduced risk of transmission of BPD features to the children of MPG-BPD participants.

It is of interest that the MPG-BPD program which principally targeted BPD mothers' parenting and capacity to relate and respond to their child, rather than their BPD symptoms independent of this context, has led to reductions in symptom levels. It

may be that targeting this core interpersonal context, of the mother with her child, is one of the major contributors to making this short, non-intensive program effective.

There is evidence that the emotional reactivity characteristic of BPD may be context-dependent and most often occurs in response to negative evaluation (Gratz, et al., 2010). This may relate to the experience of shame, as the mothers expressed strong feelings of shame regarding their interactions with their children, what they have exposed their children to (e.g., mental health issues, substance use, and intense uncontrolled anger), and not being a good enough mother. This experience of shame for BPD mothers can result in a view of self as a 'bad mother' or a 'good mother', as 'splitting' has been identified as a central defence mechanism of borderline personality organization (Kernberg, 1985).

An experimental study found those with BPD reported higher levels of shame in response to external negative evaluation compared to a non-PD control group, and significant elevations in shame remained on study completion (Gratz, et al., 2010). Shame-proneness, anger, anger rumination and BPD features have been found to be significantly intercorrelated, and it has been proposed that anger rumination may be a strategy to avoid or alter the experience of shame (Peters, Geiger, Smart, & Baer, 2014). This suggests that emotional reactivity in BPD could be improved by a reduction in the shame response to negative evaluation. There is evidence that this shame-specific reactivity may have been addressed in the MPG-BPD program, as pre-program qualitative interviews revealed participants' sense of shame in the experience of being a mother, while this was not identified at post-program nor at the six-month follow-up. Participants reported experiencing feelings of shame in other parenting programs that were not experienced during the MPG-BPD program, and they related this to the accepting and non-judgmental stance in the current program. It seems that the program

focus on being a 'good enough mother', alongside the development of acceptance, self-care, and compassion for self and others, resulted in an accepting, non-judgmental environment where the mothers became kinder and more caring to themselves, and experienced fewer negative self-evaluations and feelings of shame. This suggests that the MPG-BPD program may target a core aspect of shame for these mothers, wherein they perceive themselves as a 'bad mother'. The program provides an opportunity for the mothers to develop a sense that they are capable of improving their responses to and interactions with their children, and can be a 'good enough mother'.

It has been proposed by Fisher (1985) that "borderline clients must be given an understanding of and an opportunity for forgiveness, a way to understand and feel themselves as acceptable" (p. 106) in order to reduce the impact of shame on the client and the therapeutic relationship. High frequency and intense shame has been conceptualized as underlying BPD therapy-interfering behaviours, whereby clients may avoid discussing shame-provoking experiences that cause distress and risk vulnerability (Rizvi, 2004). It appears that the MPG-BPD program content and process facilitates the participants to feel supported in sharing such experiences, which lead to improved self-evaluations, a less dichotomous perception of self as a mother, and a reduced sense of shame. This outcome may hold significance for BPD mothers and their children, as shame is considered to be a core emotion of BPD that results in problematic behaviours such as impulsivity, anger-hostility, deliberate self-harm, and suicidal behaviours (Linehan, 1993a; Rüsch, et al., 2007).

Transformation in participants' identity from 'bad mother' to 'good enough mother' may also underlie the improvements in self-concept reported by these women. Throughout the program, the use of mindfulness for noticing automatic judgments of 'good' and 'bad', particularly in the context of parenting and self-evaluation, was

promoted. In sharing these judgments, the participants discovered that they were not alone in perceiving themselves as a 'bad' or 'incompetent' mother, and found that there were a range of negative consequences of this including emotional reactivity, guilt and shame.

> *I feel far less judgmental about myself knowing that I'm not the only person who feels that way (Jessica).*

These parenting experiences were incorporated into mindfulness psychoeducation about 'thoughts not being facts', the nonjudgmental stance, acceptance, and self-compassion. These approaches were a focus of mindfulness practice, where the mothers would pay attention to their judgments when they inevitably arose and utilise mindfulness tools such as the 'leaves on a stream' exercise in order to take a more objective stance to manage their response to these.

> *What stuck with me…the [exercise] about the leaves floating on a river and not getting stuck in one particular leaf, letting them just float past you, which really helps at night time with the thoughts (Kylie).*

> *If I'm just having a few thoughts that are quite negative – I'm more able to see that it's happening, and take some steps to go and do this or go and see a friend or do something to put the brakes on or… you know change the way I'm thinking, or just put me in a different space I guess. (Kate)*

> *I still have the negative thoughts but now I will tell myself often, and I'll have a giggle in the car, it came from the course, "oh you're having those thoughts again". I use some of those tips and I can actually get a bit of a giggle out of that (Alena).*

These aspects of the program led to participants re-evaluating their self-assessments and developing an improved self-concept with a belief that "I am a good enough mum". Considering that BPD characteristic identity problems have been associated with an implicit shame-prone self-concept (Hawes, et al., 2013), participants' improved self-concept may also result in the development of a more stable sense of self. The supportive and accepting facilitator approach of the MPG-BPD program resembles the strategy of validation in DBT, as it involves therapeutic reflection and a genuine acceptance of patients' thoughts, emotions, and behaviours (Linehan, 1993a), which is associated with a more stable sense of self (Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006).

A number of factors appear to have resulted in BPD symptomatology improvements for the mothers who participated in the MPG-BPD program, and it appears that mindfulness underlies these. DBT effectiveness studies have found mindfulness skills significantly increase over time and correlate with overall BPD symptom improvement (Nicastro, et al., 2010; Perroud, et al., 2012; Stepp, et al., 2008). ACT interventions for BPD have also resulted in BPD symptom improvements (Gratz & Gunderson, 2006; Morton, et al., 2012). Despite the efficacy of mindfulness-based interventions, it remains unclear what processes mediate mindfulness practice and symptom alleviation (Hawley et al., 2014). Information-processing models theorise that mindfulness practice leads to an enhancement in the capacity for regulating cognitions, emotions, and behaviours (Segal, et al., 2002; Shapiro, Carlson, Astin, & Freedman, 2006). Mindfulness practice has been associated with decreased rumination on distressing thought processes such as reactive self-criticism, which has been found to

correlate with significant symptom reduction (Hawley, et al., 2014). As chronic thought suppression, a maladaptive emotion regulation strategy, has been found to fully mediate the relationship between negative affect intensity/reactivity and BPD symptoms (Rosenthal, Cheavens, Lejuez, & Lynch, 2005), it supports the argument that the application of mindfulness, which is the antithesis of thought suppression, results in lessened symptom severity.

The results of the present study indicate that the MPG-BPD program addresses several characteristic symptoms of BPD, with the qualitative analyses suggesting that this is associated with increases in mindfulness and subsequent improvements in reflective functioning, emotion regulation, self-compassion, and self-concept. The apparent shift in the mothers' sense of identity from being a 'bad mother', who is incompetent and harms her child, to having the capacity for being a 'good enough mother', may have a transformative effect for stabilising participants' sense of self, but at this stage, the degree to which each of these factors influence the change process is uncertain.

11.2.6 Changes in attachment orientation.

Quantitative change in attachment orientation to a more secure attachment style was not indicated for the group as a whole on the ECR-S measure on program completion, although attachment anxiety significantly decreased six months later. There was however, some movement in the hypothesised direction for the mothers' general relationship styles on the RQ measure at program completion. Initially, the majority of participants related to the fearful attachment style on the RQ measure, which is considered an adult version of the childhood disorganised attachment style (Teyber & McClure, 2011). The preoccupied attachment style was also frequently

identified as closely characterising most participants' relationship tendencies. At program completion, the mothers' relationship styles had shifted to a secure attachment style for two participants and for another participant six months later.

These results are consistent with the attachment styles found in most people with BPD (Beatson, Rao, & Watson, 2010). Furthermore, a randomised control trial of three psychotherapy treatments for BPD (DBT, transference-focused psychotherapy, and a modified psychodynamic supportive psychotherapy) over 12-months, found that only transference-focused psychotherapy resulted in increased secure attachment organisation, while no change was found for DBT and psychodynamic supportive psychotherapy (Levy, Meehan, Kelly, & Reynoso, 2006).

Most current study participants' primary insecure attachment style tended to remain dominant despite some shifts in attachment style ratings. Some participants described improved attachment behaviours with their children, and this appears to be a consequence of the mothers having an increased awareness of secure attachment behaviours. These findings are consistent with Bowlby's (1973) proposition that attachment patterns are fairly stable from infancy to adulthood, while being open to change. Although adult attachment system organisation can be modified through social experiences that challenge prior knowledge and experience of attachment relationships, the internal working models formed in early childhood continue to exist and influence attachment patterns throughout the lifespan (Mikulincer & Shaver, 2007). As a consequence, it is unlikely that a short 12 week program would fundamentally alter attachment styles, as a 12-session group program would not provide sufficient 'corrective' attachment experiences to result in a changed attachment style orientation. As the current study assessed the mothers' general ways of relating and emotionally

connecting to others in intimate and close relationships, greater change in attachment orientation may be discovered if assessed more specifically in relation to their child.

Overall, the current pilot study outcomes indicate that the MPG-BPD program successfully facilitated positive changes in parenting and in the mother-child relationship for participants. The participants' experience of being a mother was enhanced by the program, which resulted in a range of improvements in mother-child relationship interactions, self-evaluations, self-efficacy, parenting confidence, reflective functioning, self-care, and self-compassion. Additional program outcomes included increased mindfulness, improved emotion regulation and reactivity, reduced depression and stress, and reduced BPD symptom severity. Improvements were found in the mothers' self-concept, which could relate to a shift in the identification of self from a 'bad mother' to a 'good enough mother' and the corresponding reduction in the experience of guilt. These program outcomes may have also had a positive impact on the sense of shame felt by the mothers. Although mechanisms of change were identified by the participants, this study did not directly assess the mechanisms of therapeutic change. The data and theoretical literature point to potential causal factors for the program outcomes, and the program evaluation findings specify the program content and processes that are likely to be involved. The results also suggest that change in one aspect of functioning impacts upon other facets, so that positive change promotes further improvements, with these factors influencing each other. Although the mechanisms of change require further examination, the present study demonstrates that the MPG-BPD program, a short 12-session intervention, can result in a range of positive outcomes for mothers with BPD and BPD traits, their parenting abilities, and the mother-child relationship.

11.3 Program Evaluation

11.3.1 Program process.

Qualitative analysis revealed several program processes that differentiate the MPG-BPD program from other parenting programs. Participants expressed that these particular group attributes enhanced their experience of the program in addition to their personal development as mothers and as individuals. A key difference that seems to have offset participants' sense of shame, was the focus on their personal difficulties with parenting together with a genuine non-judgemental acceptance of this. Combined with the conversational approach to skill development, this appears to have increased the participants' enjoyment of and commitment to the program. As this non-judgemental approach was modelled by the facilitators and encouraged in the mothers through the practice of compassion (both towards themselves and others), they became more comfortable to share their experiences with the group.

These program factors successfully addressed the potential barrier for BPD mothers of a fear of judgment for parenting behaviours identified in Zalewski et al.'s (2015) study. The mothers' recognised the significance of being able to share difficult parenting experiences in a safe environment while receiving support and acceptance from others with similar difficulties. This also promoted perspective taking and allowed participants to feel validated and to experience non-judgemental connections with other mothers. These experiences in the MPG-BPD program assisted these mothers with BPD and BPD traits to become less self-critical and develop greater compassion and self-acceptance. This is in line with recommendations for the inclusion of treatment approaches that are "flexibly adapted to the needs of people with BPD with chronic severe self-loathing" (Krawitz, 2012, p. 5), which include mindfulness, self-

compassion, and a therapy relationship encompassing warmth, acceptance and compassion.

The participants felt that the range of facilitator perspectives, and the professional level of disclosure, enriched their experience of the program as it allowed for a sense of shared humanity and increased the therapeutic alliance. This outcome provides further support for the strength of appropriate disclosure in the therapeutic stance of Yalom (2005) and ACT (Harris, 2006, 2009), and indicates that this program process resulted in strengthening the therapeutic alliance, a significant outcome considering the importance and difficulty of developing this with BPD clients (Barnicot, et al., 2012; Barnicot, et al., 2011; Linehan, 1989). Having three female program facilitators with varied parenting experience was viewed positively by the mothers, and allowed for sessions to continue with two facilitators while the third provided individual support when a participant became distressed.

Additionally, the mothers' expressed that by allowing concepts and individual difficulties to be discussed in greater depth, they were encouraged to view their contributions positively and feel an even greater level of support. Containing conversations around individual concerns was difficult at times and the facilitators had to work at maintaining a balance between covering the session content, allowing participants to feel heard and supported when discussing their difficulties with the group, and ensuring that all participants had an opportunity to contribute. The focus group feedback indicated that the facilitators successfully managed this, but also indicated that longer sessions or a longer program would improve this.

The clinical psychologist conducted a supervision group following each MPG-BPD program session. The supervision group provided an opportunity to reflect on each session and participant improvements, discuss any participant or facilitator issues

that arose during that session, discuss participant formulations, and the identification of potential individual or group issues and how to manage them.

11.3.2 Program content.

Post-session feedback data revealed that the majority of participants found the content of all 12 sessions to be highly relevant and/or useful, with the emotion-focused sessions amongst the most highly rated. Although this emotion regulation focus is also included in DBT, MBT and ACT, the participants in the current study developed emotion regulation skills in the context of parenting. Rather than reacting with outbursts of anger, ignoring their child, or using substances, the mothers learnt to identify their emotional responses to their child and apply mindfulness and compassion to act in a more considered manner, which improved mother-child relationships, and decreased the mothers' feelings of guilt and shame.

Throughout the program, the participants reported a belief that mindfulness was helpful for being a mother and for life more generally. This may relate to the approach taken to mindfulness psychoeducation in early sessions, where facilitators highlighted the practical applications of mindfulness for difficulties experienced by BPD mothers and parenting. In accordance with Jon Kabat-Zinn's statement that "the teaching has to come out of one's practice" (cited in McCown, Reibel, & Micozzi, 2010, p. xviii), the facilitators shared their own experiences of learning and practicing mindfulness, and emphasised how mindfulness has been helpful for parenting and emotion management. Throughout the early sessions, the facilitators stressed that there is no 'right' or 'wrong' way to practice mindfulness, that individuals may have preferences for different mindfulness-based practices, that it can take time to develop mindfulness, the importance of having realistic expectations, and discussed obstacles to mindfulness.

This attitude of facilitators, which reflect both authenticity and authority (McCown, et al., 2010) along with the promotion of a nonjudgmental stance seems to have encouraged the mothers to practice mindfulness without judging their own efforts nor evaluating themselves as either 'succeeding' or 'failing' at mindfulness. This is an important factor, as this approach to mindfulness psychoeducation enhanced the likelihood that participants would be willing to engage in mindfulness practice and apply mindfulness techniques in parenting and for emotion management.

Qualitative interviews revealed that participants viewed mechanisms of change to include attachment theory, reflection on family of origin, the 'good enough mother' concept, mindfulness, and self-compassion; although the relative importance of these factors was not assessed in the present study.

By encouraging reflection on participants' own childhood attachment relationships in conjunction with attachment psychoeducation, the mothers were able to develop a greater understanding of themselves and their parenting behaviours, while also developing compassion about, and acceptance of, their experiences and themselves. Consistent with recommendations for family violence child-parent psychotherapy (Lieberman & Van Horn, 2005), the MPG-BPD program provided mothers with compassion for what they have endured while promoting reflection about their child's experience and internal representations. It appears that this component of the program assisted participants to understand and process their own experiences of childhood attachment trauma and motivated them to spare their children from similar kinds of experiences, while also providing tools to facilitate this. Participants' considered the Circle of Security attachment model to be a valuable component of the program that helped them to understand their child's attachment needs as well as identify their own

unmet childhood needs. These components appear to have addressed participants' unresolved attachment traumas, and allowed the mothers to identify and discuss these childhood experiences, which may have led to an increased ability to be present and emotionally available to their children (Lamont, 2006; Newman & Stevenson, 2005).

The good enough mother concept was identified as having assisted participants with developing self-compassion and self-acceptance, allowing participants to have more realistic expectations of themselves as mothers and reduce their negative self-evaluations. These program components appear to have resulted in participants developing an increased ability to identify and respond to their children's attachment needs in a way that is 'good enough', and further increasing their tolerance for being present and mindful with their child. These improvements in mother-child interactions and in the experience of motherhood, alongside an awareness of providing their child with a parenting experience that differs from their own, may have allowed the mothers an opportunity to shift their self-identity from the shameful 'bad mother' (Goodwin & Huppatz, 2010) to the 'good enough mother' (Winnicott, 1953).

The mindfulness focus and in-session practice was considered helpful for developing a positive view of self, greater acceptance, and improving responses to difficult thoughts and emotions. Although participants found the emotion-focused aspect of the program challenging, quantitative and qualitative results highlight the importance of this component for a range of positive program outcomes. All participants in the focus groups reported the emotion psychoeducation, discussion, and the use of mindfulness for managing emotions to be amongst the most helpful program content. The qualitative interviews revealed that the mothers had become more aware of their emotions, and found it helpful to identify, observe and accept these emotions, rather than automatically react to, or attempt to, avoid emotional experiences:

Usually because I pay attention to an emotion or a feeling, that alerts me to something going on inside. And I try to figure out where it's coming from, and I decide then how I'm going to react, as opposed to just barging in (Fiona).

I've no longer been retreating into that fog that the drugs gave me. I have to deal with things as they are…and if things are upsetting me I won't let it all sort of float away, I have to deal with it. (Jessica)

The women found that adoption of this observing stance reduced the tendency to become caught up in and overwhelmed by their emotions. As Kylie reported, "I try and separate myself from them [difficult emotions]. In that, yes they're there but they don't have to consume me." An important outcome of this emotion-focused program content was the reduction in the mothers' emotional reactivity towards their children:

I think I'm more aware of the kids; and more times now I can catch myself and be calmer in my approach with them. I don't fly off the handle like I did, every time (Kate).

Just in general everyday life when I'm about to lose it at (son) I try and take a breath or re-think why I'm about to yell or scream. (Kylie)

I do it differently. I think where I used to just scream and explode...I now control it. (Aisyah)

11.3.3 Program improvement.

The participants made several suggestions for program improvement, which included an increase in the program and/or session length to allow for a more detailed discussion of the content and individual experiences. A further suggestion was to add booster sessions following program completion. Such an addition would lessen difficulties that could arise for participants around therapy termination, as individuals

with BPD and BPD traits tend to have high sensitivity to perceived rejection and abandonment (Aviram, Brodsky, & Stanley, 2006; Westbrook & Jackson, 2009). Booster sessions would also assist participants to reconnect with one another, experience continued support, and acknowledge their achievements over time. Additional suggestions included the provision of individual support with a facilitator as an adjunct to the program, and childcare access to facilitate program attendance.

11.4 Addressing Recommendations for Interventions Targeted at Mothers with BPD

The MPG-BPD program was developed to address a gap in the treatment and research of mothers with BPD in line with recommendations from the Australian clinical practice guidelines for the management of BPD and Stepp et al.'s (2012) review. The program provided a structured psychological therapy that was specifically designed for mothers with BPD to support parenting skills and attachment relationships, incorporating psychoeducation and mindfulness-based strategies. Although attachment-based parenting interventions such as Minding the Baby, COS, and WWW promote parenting skills and attachment relationships, because they have not been designed specifically for mothers with BPD, they may not sufficiently address the needs of this population. Newman and Stevenson (2008) identified a number of difficulties that occurred when implementing the WWW intervention with BPD mothers, which appeared to be BPD-specific and related to the child-focused nature of the intervention. The MPG-BPD program minimised these potential issues by implementing the intervention with BPD mothers without their children being present. This also addressed concerns of BPD mothers about the behaviours of other mothers and their children which was identified in Zalewski et al.'s (2015) prospective PC-DBT study.

The MPG-BPD program also addressed the "urgent need for accessible, appropriate treatment for people with BPD" (National Health and Medical Research Council, 2013, p. 120). Effective short-term interventions are required to assist with the large volume of clinical demand, as long-term treatments such as DBT or MBT can have waiting lists of one to two years (Greyner & Fanaian, 2015). The Project Air Parenting with Personality Disorder intervention (Project Air Strategy for Personality Disorders, 2015a) also addresses these recommendations, although it is yet to be determined whether the brief three-session intervention is sufficient and effective for improving outcomes for parents with BPD and their children, and whether outcomes are maintained over time. The recent development of MBT-P and PC-DBT interventions for parents with BPD also address the needs of BPD mothers, though outcome studies are yet to be published. Considering the efficacy of MBT and DBT for BPD, these interventions are likely to provide a promising integration of BPD treatment and parenting principles to address the current gap in treatment and research. If these programs are of a lengthy duration, similar to standard MBT and DBT approaches, this may present an obstacle to accessibility and attendance for mothers with BPD due to caring for a young child and difficulties committing to a therapeutic relationship.

The MPG-BPD program successfully addresses the gap in treatment and research by following recommendations for intervention and designing a group treatment specifically for mothers with BPD. Rather than adapting an existing parenting intervention or BPD treatment approach, this program incorporated the seemingly most relevant and beneficial aspects of several BPD treatments and parenting interventions in order to address BPD-specific issues within a parenting context. The program was designed to be implemented over 12 sessions to increase accessibility for participants, which could be further improved by providing access to child-care.

11.5 Overview and Implications

This study of the MPG-BPD program aimed to address the need for treatment and research in parenting interventions specifically targeting mothers with BPD. Results indicate that the MPG-BPD program is beneficial for mothers with BPD and can result in a range of outcomes including positive changes in parenting, in the experience of being a mother, and for the mother-child relationship. Additionally, the MPG-BPD program outcomes include improvements in emotion regulation, mindfulness, reflective functioning, BPD symptom severity, self-concept, self-care, and mood.

Both the quantitative and qualitative results support the efficacy of a group intervention program that combines evidence-based components from three major BPD treatments (DBT, MBT, and ACT) and parenting interventions based on attachment and mindfulness. Participation in this MPG-BPD program led to significant quantitative improvements in mindfulness, the interest and curiosity dimension of parental reflective functioning, emotion regulation, depression, stress, and BPD symptom severity. The MPG-BPD program also resulted in a range of qualitative improvements for the participants and for the mother-child relationships. Improvements were found in reflective functioning, self-concept (including reduced self-criticism and increased self-efficacy), self-care incorporating self-compassion, awareness, and acceptance. Improved mother-child relationship outcomes included an increased awareness of children's attachment needs, improved parenting interactions, and improved communication between participants and their children. Qualitative results also revealed improvements in BPD symptomatology, particularly for interpersonal relationships, affective stability incorporating mood reactivity and anger control,

impulsivity and substance use. The qualitative findings also demonstrated reductions in guilt and indicated a possible reduction in the experience of shame.

The program evaluation results differentiated the MPG-BPD program from other parenting programs, with the program process playing a major role in a positive program experience for the participants as individuals and as mothers. The program processes implicated in this were the focus on individual difficulties with parenting and more generally, a non-judgemental compassionate stance as modelled by the facilitators, the experience of sharing in a supportive and accepting group environment, therapeutic disclosure, and program flexibility. Participants found the program content to be highly relevant and/or useful, with the emotion-focused content considered to be the most relevant and/or useful to the mothers. The mechanisms of change identified qualitatively were mindfulness, self-compassion, reflection on family of origin, the 'good enough mother' and attachment theory. The findings of the present study support the thesis that the MPG-BPD program is an effective intervention for addressing BPD-specific parenting difficulties experienced by mothers with BPD and BPD traits, and results in positive changes to parenting, the mother-child relationship, and general psychological functioning.

11.6 Difficulties Recruiting and Maintaining Attendance of Clients with BPD

The group program was conducted twice due to recruitment difficulties and low participant numbers in the initial pilot program. It is notable that for Group 1, 50% of participants deemed eligible for the initial assessment actually attended, while there was 100% attendance for Group 2. Difficulties associated with participant recruitment appear to have been reduced by the program being conducted within the same service and location from which participants were referred, as was the case for Group 2.

Childcare was explored as an option during program development, but due to the limited funding available for this research project, it was unfortunately not possible to offer childcare to participants as a component of the program. This notably impacted on participant recruitment, as during the initial telephone screening process several mothers with younger children enquired about childcare and stated that they would be unable to attend the program without childcare being offered or bringing their child to sessions.

Although the study has a small sample size of seven participants, as noted by Newman and Stevenson (2008): "it is important to remember that mothers with BPD have difficulties in attending appointments and committing to a therapeutic relationship". Average BPD group psychotherapy session attendance rates have been found to be 77% (Gagnon, Leblanc, & St-Amand, 2015). BPD features such as interpersonal and emotional reactivity, impulsivity, and anger contribute to the higher rates of treatment dropout for those with BPD compared to other disorders (Wnuk et al., 2013). The attrition rate in the current study was 22%, with two participants withdrawing prematurely due to receiving alternative mental health treatment that was considered a priority. This compares favourably to the average attrition rate of 38% across randomised outcome studies of psychotherapy with BPD patients (Jørgensen et al., 2009; Wnuk, et al., 2013). Considering that the therapeutic alliance was the strongest predictor of dropout found in Wnuk et al.'s (2013) study of BPD treatment dropout variables, this indicates a strong therapeutic alliance existed between the mothers and facilitators of the MPG-BPD program.

As detailed in the method, two participants attended all 12 sessions and two attended 11 sessions, with six of the seven ongoing participants attending at least seven sessions. The post-program feedback questionnaires and focus groups were completed and attended by the four participants who attended 11 or 12 sessions. This may have

impacted on the program evaluation, as these participants are likely to have benefited more from the program compared to the three participants who missed 4 to 7 sessions. Although attendance was erratic at times for some participants, the majority of participants attended the majority of sessions. These promising attendance rates could be related to the program processes such as the focus on individual and parenting difficulties, the non-judgemental compassionate support provided by facilitators and modelled to participants, sharing with mothers who have similar difficulties, program flexibility, and therapeutic alliance.

11.7 Child Effects

Considering the importance of parenting on child attachment and outcomes in maternal BPD, the current study would have been improved by assessing child attachment behaviours and child outcomes alongside the measurement of the mothers' outcomes. A range of child effects can impact on the mother-child relationship, such as child temperament. The interplay between maternal personality and child temperament has been found to impact on mothers' responses to their children, with maternal behaviour also affected by the situational context (Clark, Kochanska, & Ready, 2000). For example, a mother with limited empathic or reflective functioning abilities, as is common in maternal BPD, is likely to have difficulty understanding her infant's cues and conceptualising an appropriate soothing response. If this mother has an infant with high negative emotionality and low soothability, this dyad is likely to result in a trajectory that is mutually aversive. Furthermore, interactions between maternal personality traits and infant emotionality have been found to predict attachment security (Mangelsdorf, Gunnar, Kestenbaum, Lang, & Andreas, 1990).

Intervention research has demonstrated that training parents to respond to the specific needs of their individual child, whereby mothers of infants assessed as irritable were trained in how to soothe and play with their children, resulted in greater positive behaviours displayed by both the mothers and children, as well as higher levels of secure attachment over time (van den Boom, 1994; van den Boom, 1995). Due to temperamental differences in response to similar patterns of parenting, parental awareness and adaptability to their child's temperamental characteristics is an important factor in any parenting program (Putnam, Sanson, & Rothbart, 2002). The application of a temperamental-based approach to parenting has been found to result in improved parent-child relationships, as well as greater positive outcomes for parents (Sheeber & Johnson, 1994). This highlights the value of incorporating a temperamental-based component in the MPG-BPD program through the inclusion of temperament psychoeducation, developing profiles of participants' children's temperamental profiles, and making goodness-of-fit recommendations for specific parenting strategies.

11.8 Limitations of the Current Study

As the current study was focused on treatment development and evaluation, there were several limitations. These limitations point towards possible refinements and extensions to future BPD parenting intervention program design, delivery and evaluation research. The small sample size was due to the previously discussed recruitment difficulties, and future program implementation with a larger sample including a broader participant age range is necessary to confirm the study findings. Six mothers aged in their 40s and one mother in her late 20s participated in the current study. As stability tends to increase for individuals with BPD in their 30s and 40s (American Psychiatric Association, 2013), the mothers in the sample may not be

representative of BPD mothers more generally. However, the age range of this sample may indicate a greater readiness of BPD mothers to participate in a parenting intervention at this stage of life, and this willingness and motivation may have partially driven the program outcomes.

Mothers with BPD traits were included in this pilot study due to difficulties recruiting a sample of mothers who met criteria for a BPD diagnosis. The results indicate that the MPG-BPD program is beneficial for mothers who meet diagnostic criteria for BPD as well as those who meet subthreshold levels of BPD. However, it is necessary to replicate this study with a sample of mothers who meet criteria for BPD diagnosis in order to confirm that the MPG-BPD program is an effective treatment intervention for mothers with BPD.

In terms of the research design used in this study, it would have been preferable to include a comparison group that did not participate in the MPG-BPD program in order to clearly ascribe the reported changes to treatment effects. A control group was not included due to the previously mentioned population recruitment difficulties and the scope of the research being within a professional doctorate program. Lack of a control group limits the possibilities to draw conclusions about the efficacy of the MPG-BPD program. As the participants varied in the degree to which they were engaged in other therapeutic treatment, it is unclear what proportion of change was due to the program or accounted for by other therapeutic supports. Major life events are another extraneous factor that may have affected participant outcomes. For example, during the program Aisyah reported increased stress due to the demands of building the family home. This resulted in erratic attendance and appears to have affected her post-program outcomes. It is not unusual for individuals with BPD to experience negative events and crises in their lives, often as a result of relationship and emotional instability (Jovev & Jackson,

2006; National Institute for Health and Clinical Excellence, 2009). In order to identify more clearly the effects of the MPG-BPD program it is important to replicate this program with control groups that can assess, and statistically control, for these and other extraneous factors. For example, Bohus et al. (2004) evaluated the effectiveness of inpatient DBT for BPD using a control group. Although the variables of major life events/crises and additional therapeutic treatment were not assessed, Bohus, et al. (2004) controlled for a number of extraneous variables at pre-treatment by using matched samples including age, comorbid disorders, psychiatric hospitalisations and suicide attempts. The authors further statistically controlled for social variables (including age and current employment), pre-treatment history, and the severity of BPD diagnosis and medication on treatment outcomes. Future studies might use a major life events scale (e.g., The Social Readjustment Rating Scale; Holmes & Rahe, 1967) to statistically control for major life events given the instability often characteristic of the lives of women with BPD.

Although changes in mindfulness were measured, the amount and type of mindfulness practice participants engaged in outside of the program sessions was not formally measured. It would be useful to evaluate the effect of mindfulness practice on participant outcomes, as this would provide evidence for recommendations made to participants about practicing mindfulness outside of sessions. Additionally, a specific measure to assess the frequency of participants' engagement in mindful parenting behaviours with their children would provide stronger evidence for the mothers' changed parenting practices and that a mindful approach to parenting was a mechanism of change.

The parental reflective functioning quantitative findings were limited by the use of the PRFQ (Luyten, et al.), as it is designed for parents of children age 0-5 and only

one participant in the current study had a child aged under 5. The PRFQ authors acknowledge that this measure may not accurately assess reflective functioning in parents of children over 5 years. This may account for the strong qualitative findings of increased reflective functioning in contrast to the unexpected minimally significant quantitative improvements in parental reflective functioning. Parental reflective functioning may be best assessed qualitatively as has been done by Sadler, et al. (2013) due to the complexity involved, which could account for why almost all reflective functioning measures are interviews. Future MPG-BPD studies should assess RF using a well validated qualitative measure (Fonagy, et al., 1998; Slade, Aber, Bresgi, Berger, & Kaplan, 2004) better explore change in this area and confirm the qualitative findings of the present study.

Because resources were limited, program evaluation was conducted by program facilitators which may account for the minimal negative feedback from participants, despite the encouragement of criticism for program improvement purposes. In order to validate these results, future program evaluation should be conducted by independent researchers to reduce the occurrence of responses that participants think are pleasing to the interviewer.

11.9 Strengths of the Current Study

Despite these limitations, this study has some important strengths which should be acknowledged. The mixed-methods design of the study allowed for a more complete picture of the MPG-BPD program to be obtained. The quantitative results provide support for the effectiveness of the MPG-BPD program in generating positive changes in parenting and psychological functioning. The qualitative results enhanced and enriched the information about program outcomes, which augment and clarify the

quantitative findings. Incorporating a mixed-methods approach to program evaluation provided important information about the participants' experience of the MPG-BPD program, and considerations for program improvement. By allowing participants to explain their experiences and explore the mechanisms through which they believe change occurred for them, a deeper understanding of the program was achieved.

The program design of having mothers participate without their children allowed participants to discuss their issues openly without distraction, or concern for, their children. This appears to have reduced any potential maternal resentment due to their child receiving attention that the participants did not receive in their own childhood, as observed in Newman and Stevenson's (2008) study. This also allowed the mothers to feel that the program addressed their personal needs, as well as their parenting issues. Additionally, by not including participants' children in the program, facilitators were able to focus on working with the mothers' experiences in a compassionate manner without being affected by their own emotional response to witnessing potentially limited responses by the mothers towards their children, which was also noted in Newman and Stevenson's (2008) study.

11.10 Directions for Future Implementation and Research

While this thesis provides evidence for the efficacy of the MPG-BPD intervention program, further research is required. Replication of this program with a randomised controlled design and a larger sample size is required to verify that the results obtained in this study reflect the effects of the intervention. To confirm the present findings and generalise the results to a broader population of mothers with BPD, future research should involve mothers of varied ages who meet criteria for a BPD diagnosis. It would be useful for future studies to further explore which particular BPD

criterion symptoms decrease as a result of the program, to what extent these symptoms decrease, whether these reductions result in diagnostic changes, and whether these reductions in symptomatology are maintained over time.

Research exploring the mechanisms of change in the MPG-BPD program would clarify the efficacy of program content and process, and indicate which program aspects brought about the specific improvements, which is particularly important due to the overlapping theoretical components involved. Within-intervention assessment would allow for a more detailed examination of the mechanisms of change and intervention effectiveness. This could involve the completion of post-session assessment measures in order to track change from session to session. This approach was used by Dick, Niles, Street, Dimartino, and Mitchell (2014) to examine the effect of a yoga intervention for women, where participants completed questionnaires after each session to track changes in mindfulness, psychological flexibility, emotion regulation, and PTSD symptoms, which were compared to changes in a control group. Tracking change during the intervention could involve questionnaire and/or interview assessments at various time points. For example, Dekovic, Asscher, Manders, Prins, and van Der Laan (2012) assessed whether improvements in parental sense of competence during multisystemic therapy resulted in positive parenting changes and subsequently reduced adolescent externalising problems. This involved monthly telephone interviews using shortened versions of pre and post assessment questionnaires, which allowed for a comparison of the treatment group and control group trajectories during the intervention period.

If funding were available, a more intensive time-sampling observational methodology might be used to track the change process. Here participants' interactions with their children are observed, and particular behaviours are recorded at certain time

points across the course of the program. This method has been used successfully to identify a range of parent and child behaviours to assess the outcomes and mechanisms of change of a parenting intervention for reducing child conduct problems (Gardner, Burton, & Klimes, 2006). In Gardener et al.'s study, parent-child interactions in six structured settings within the home were recorded by video camera to sample a range of everyday situations that were pleasurable and more stressful. This approach was used to evaluate changes in positive and negative parenting skills, as well as child problem behaviour. Such an approach could be adopted so that research might track participants' emotion regulation improvements within the context of parenting, particularly in the face of stressful parenting situations that often elicit difficult emotions.

Considering the impact of child effects and the mother-child relationship dyad, the MPG-BPD program could be further strengthened by inclusion of a component of the intervention that involves the children of participants. Due to the scope of the current pilot study and anticipated participant recruitment difficulties, the inclusion criteria allowed for mothers of children across a broad age range of 1 to 10 years. As the majority of participants' children were of school age, it was not necessarily appropriate for the children to attend the program with their mothers due to the content of discussions. However, the program could benefit from the inclusion of assessments that measure parenting practices, the mother-child interactions, and children's attachment behaviours, in order to assess for mechanisms of change. This could possibly be implemented through the use of videorecording mother-child interactions for measurement, as well as enhancing the intervention outcomes by playing carefully selected vignettes of these recordings for observation and reflection during group sessions, as implemented in the COS intervention protocol (Marvin, et al., 2002). This

could be applied in a cost effective manner by asking the mothers to interact with their children in specified play activities with each dyad being separately recorded in the home environment, with a friend or family member videorecording this unobtrusively using a smartphone.

It would be useful to assess the process and impact of various mechanisms of change to develop a greater understanding of the program effect and to ascertain the relative importance of these. For example, a closer investigation into the sense of shame and how this may have altered over the program period is of interest. This could involve a general assessment of shame using a measure such as the Experience of Shame Scale (Andrews, Qian, & Valentine, 2002), shame-proneness using a measure such as the Test of Self-Conscious Affect (Tangney, Wagner, & Gramzow, 1989), and a qualitative assessment of the sense of shame and identity in the context of motherhood. Assessing these aspects of shame throughout the program could clarify the mechanisms of change that result in the qualitative findings of the mothers' reported experience of a reduction in shame. Such a procedure has been effectively used by Kelly, et al. (2014) to indicate that eating disorder patients in group-therapy treatment programs who reported greater increases in self-compassion early in treatment had faster reductions in shame and eating disorder symptoms over 12 weeks of treatment.

Considering that shame has been identified as the central emotion in BPD and is associated with implicit self-concept (Rüsch, et al., 2007), it would be of value to explore the process of change regarding shame and the impact of shame on participants' self-identity. Such a study might also track the mechanisms of shame reduction and related emotional changes. As indicated by Linehan (1993a) and Crowe (2004), when shame is triggered by the self being evaluated negatively, this often results in a response

of uncontrollable negative affect in women with BPD. Further exploration into the relationship between shame and self-identity would allow more detailed empirical examination, and help to confirm the qualitative findings that suggest participants' experienced a change in self-identity from that of a shameful 'bad mother' who is highly self-critical, to that of a 'good enough mother' who is capable of improved engagement and responsiveness to their child. This good enough mother who is less likely to experience shame, also seems to be less likely to become emotionally reactive and engage in uncontrolled emotional outbursts with her child. While quantitative findings have indicated the mothers in this study became better able to manage their emotions, and the qualitative findings indicate that this was often in relation to interactions with their children, there needs to be careful empirical tracking to establish whether this proposed mechanism of change applies and to what degree.

Longitudinal research of the MPG-BPD program is also necessary to determine the maintenance of changes brought about by treatment. An additional 1-year follow-up assessment would permit examination of potential long-term program effects on participants and their children. The focus group participants made suggestions about increasing the program length, having booster sessions, and having an ongoing monthly group. To evaluate the effectiveness of such additional components, follow-up assessments could be conducted with participants attending post-program sessions and compared with follow-up assessments with those not attending these sessions. Bateman and Fonagy (2001) described a similar approach in the longitudinal evaluation of MBT for BPD, where a follow-up program of twice-weekly group therapy over 18 months was offered to the participants who had completed the initial MBT treatment. Further assessment was conducted at the end of this follow-up period and again at an 8-year follow-up, and these were compared to a control group to establish the efficacy of MBT

for BPD compared to treatment as usual (Bateman & Fonagy, 2008a). Although longitudinal research is fraught with difficulties, considering the chronic nature of BPD, and the outcomes for children of BPD mothers, it is especially important to evaluate whether more long term interventions have a beneficial effect. Bateman and Fonagy found their extended program resulted in improvements in BPD symptomatology and mother-child interactions, such that there may be a subsequent reduction in the risk of transmitting attachment patterns and BPD features from mother to child, and possibly improved developmental, psychological and social outcomes for the participants' children. Future studies might consider extensions to the current MPG-BPD program and longitudinal tracking of subsequent changes for both mothers with BPD and their children.

As the MPG-BPD program has a specific focus that addresses BPD difficulties in relation to parenting, it is recommended that participants also be engaged in individual therapy so that they receive additional support that cannot be provided in the scope and context of the program. It is important to note that the participants themselves identified this as a beneficial program supplement. As there appears to be some attrition, but not to the extent of other BPD groups, the initial group size could start at eight participants. In the future, if there is enough participant recruitment/interest, separate groups could be conducted based upon age groups of the participants' children. This would allow for an additional focus on parenting issues that relate to children at differing developmental stages.

Based on participant feedback and facilitator reflection, it is recommended that future development of the MPG-BPD program entail at least twelve sessions of three-hour duration (including a break), with a gradual tapering down of session frequency, so

that the first ten sessions are conducted weekly, then fortnightly. Following program completion, it is recommended that over the course of the next year and a half, booster sessions be run monthly, then two-monthly and then three monthly. Based on feedback from participants, the program would be best conducted during school hours and it would be ideal to have some form of childcare provision available for pre-school aged children.

A potential area for future research could involve professionally moderated internet forums for participants following program or booster session completion. The limited research of e-health tools for BPD suggest positive outcomes. For example, a German study found clients with BPD were widely accepting of this therapeutic tool, which led to reductions in BPD symptom severity (Habermeyer et al., 2009). Fassbinder et al. (2015) recommend a combination of face-to-face psychotherapy and specialized e-health tools for BPD treatment, as this can allow for increased opportunity for training, experience, and repetition that can deepen psychoeducational content. Additionally, e-therapy can facilitate the generalization of treatment effects to the natural environment, empower participants, and reduce dependency on face-to-face psychotherapy. A pilot study of an e-health tool combined with face-to-face schema therapy for BPD indicated that the integration of e-health into BPD-specific treatment can potentially increase treatment intensity and enhance treatment effects (Fassbinder, et al., 2015).

11.11 Conclusion

This study supports the effectiveness of an integrated treatment approach for an intervention targeting parenting difficulties experienced by mothers with BPD traits. Considering the findings of this pilot study, the MPG-BPD program successfully

addressed the treatment gap of parenting interventions specifically targeted at mothers with BPD, and resulted in a range of positive outcomes for participants, and potentially for their children as well. The present study makes a contribution to the research in this area, and draws attention to the need for specific interventions to be developed for mothers with BPD.

It is for future research to demonstrate more powerfully that if mothers with BPD can have a safe and supportive space to share difficult and distressing experiences with other mothers and facilitators, without experiencing judgment, that this is immensely meaningful, and allows for transformation in the mothers' sense of self and the way they interact with their children. Mothers in this study seemed to develop a belief that they can be 'good enough mothers'. While at present there is only preliminary, mainly qualitative data, to support this change, other data does indicate change that appears real in improved BPD symptoms, depression, stress, emotion regulation, mindfulness and parenting. More controlled and systematic studies are needed to indicate how much the program itself and various aspects of the program influenced these changes. More detailed analysis is also required to document the change process for mothers to reveal why all mothers reported the intervention to be a unique and valuable experience.

References

Abidin, R. R. (1995). *Parenting Stress Index: Professional Manual*. Florida: Psychological Assessment Resources, Inc.

Achenbach, T. (2000). *Child Behavior Checklist for Ages 1½-5*. Burlington, VT: University of Vermont.

Achenbach, T. (2001). *Child Behavior Checklist for Ages 6-18*. Burlington, VT: University of Vermont.

Agrawal, H. R., Gunderson, J., Holmes, B. M., & Lyons-Ruth, K. (2004). Attachment Studies with Borderline Patients: A Review. *Harvard Review of Psychiatry, 12*(2), 94-104.

Ainsworth, M. D. S. (1967). *Infancy in Uganda: Infant care and the growth of attachment*. Baltimore: Johns Hopkins University Press.

Ainsworth, M. D. S., & Wittig, B. A. (1969). Attachment and exploratory behavior of one-year-olds in a strange situation. In B. M. Foss (Ed.), *Determinants of infant behavior* (Vol. 4, pp. 113-136). London: Methuen.

Ainsworth, M. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Oxford England: Lawrence Erlbaum.

Allen, J. G., & Fonagy, P. (2014). Mentalizing in Psychotherapy. In R. E. Hales, S. C. Yudofsky & L. Weiss Robers (Eds.), *The American Psychiatric Publishing Textbook of Psychiatry* (6th ed.). Washington, D.C.: American Psychiatric Publishing.

Allen, J. G., Fonagy, P., & Bateman, A. W. (2008). *Mentalizing in Clinical Practice*. Washington D.C.: American Psychiatric Publishing.

American Psychiatric Association. (1980). *Diagnostic and Statistical Manual of Mental Disorders* (Third ed.). Washington, DC: American Psychiatric Association.

American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders* (Text Revision, Fourth ed.). Washington, DC: American Psychiatric Association.

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (Fifth ed.). Arlington, VA: American Psychiatric Association.

Anderson, C. L., & Alexander, P. C. (1996). The relationship between attachment and dissociation in adult survivors of incest. *Psychiatry-Interpers. Biol. Process., 59*(3), 240-254.

Andrews, B., Qian, M., & Valentine, J. D. (2002). Predicting depressive symptoms with a new measure of shame: The Experience of Shame Scale. [Article]. *British Journal of Clinical Psychology, 41*(1), 29.

Antony, M. M., Bieling, P. J., Cox, B. J., Enns, M. W., & Swinson, R. P. (1998). Psychometric properties of the 42-item and 21-item versions of the Depression Anxiety Stress Scales in clinical groups and a community sample. *Psychological Assessment, 10*(2), 176-181.

Appel, J., & Kim-Appel, D. (2009). Mindfulness: Implications for Substance Abuse and Addiction (Vol. 7, pp. 506-512).

Arvidson, J., Kinniburgh, K., Howard, K., Spinazzola, J., Strothers, H., Evans, M., . . . Blaustein, M. E. (2011). Treatment of Complex Trauma in Young Children: Developmental and Cultural Considerations in Application of the ARC Intervention Model. *Journal of Child & Adolescent Trauma, 4*(1), 34-51.

Astin, J. A. (1997). Stress reduction through mindfulness meditation - Effects on psychological symptomatology, sense of control, and spiritual experiences. [Article]. *Psychotherapy and Psychosomatics, 66*(2), 97-106.

Australian Parliament Senate Select Committee on Mental Health. (2006). *A national approach to mental health – from crisis to community*. Canberra: Commonwealth of Australia.

Australian Parliament Senate Standing Committee on Community Affairs. (2008). *Towards recovery: mental health services in Australia*. Canberra: Commonwealth of Australia.

Aviram, R., Brodsky, B. S., & Stanley, B. (2006). Borderline personality disorder, stigma, and treatment implications. *Harvard Review of Psychiatry, 14*(5), 249-256.

Baer, R. A. (2003). Mindfulness training as a clinical intervention: A conceptual and empirical review. [Review]. *Clinical Psychology-Science and Practice, 10*(2), 125-143.

Baer, R. A., Smith, G. T., Hopkins, J., Krietemeyer, J., & Toney, L. (2006). Using Self-Report Assessment Methods to Explore Facets of Mindfulness. *Assessment, 13*(1), 27-45.

Bagby, R. M., & Farvolden, P. (2004). The Personality Diagnostic Questionnaire-4 (PDQ-4). In M. J. Hilsenroth & D. L. Segal (Eds.), *Comprehensive handbook of psychological assessment, Vol. 2: Personality assessment.* (pp. 122-133). Hoboken, NJ, US: John Wiley & Sons Inc.

Bales, D., van Beek, N., Smits, M., Willemsen, S., Busschbach, J. J. V., Verheul, R., & Andrea, H. (2012). Treatment Outcome of 18-Month, Day Hospital Mentalization-Based Treatment (MBT) in Patients with Severe Borderline

Personality Disorder in the Netherlands. *Journal of Personality Disorders, 26*(4), 568-582.

Bandura, A. (1996). Regulation of cognitive processes through perceived self-efficacy. In G.-H. Jennings (Ed.), *Passages beyond the gate: A Jungian approach to understanding the nature of American psychology at the dawn of the new millennium.* (pp. 96-107). Needham Heights, MA England: Simon & Schuster Custom Publishing.

Barnicot, K., Katsakou, C., Bhatti, N., Savill, M., Fearns, N., & Priebe, S. (2012). Factors predicting the outcome of psychotherapy for borderline personality disorder: A systematic review. *Clinical psychology review, 32*(5), 400.

Barnicot, K., Katsakou, C., Marougka, S., & Priebe, S. (2011). Treatment completion in psychotherapy for borderline personality disorder: A systematic review and meta-analysis. *Acta psychiatrica Scandinavica, 123*(5), 327.

Barnow, S., Aldinger, M., Arens, E. A., Ulrich, I., Spitzer, C., Grabe, H. J., & Stopsack, M. (2013). Maternal Transmission of Borderline Personality Disorder Symptoms in the Community-Based Greifswald Family Study. *Journal of Personality Disorders, 27*(6), 806-819.

Barnow, S., Spitzer, C., Grabe, H. J., Kessler, C., & Freyberger, H. J. (2006). Individual characteristics, familial experience, and psychopathology in children of mothers with borderline personality disorder. [Research Support, Non-U.S. Gov't]. *Journal of the American Academy of Child and Adolescent Psychiatry, 45*(8), 965-972.

Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology, 61*(2), 226-244.

Basco, M. R., Bostic, J. Q., Davies, D., Rush, A. J., Witte, B., Hendrickse, W. A., & Barnett, V. (2000). Methods to improve diagnostic accuracy in a community mental health setting. *American Journal of Psychiatry, 157*, 1599-1605.

Bateman, A., & Fonagy, P. (1999). Effectiveness of partial hospitalization in the treatment of borderline personality disorder: a randomized controlled trial. *The American Journal of Psychiatry, 156*(10), 1563-1569.

Bateman, A., & Fonagy, P. (2001). Treatment of borderline personality disorder with psychoanalytically oriented partial hospitalization: An 18-month follow-up. *The American Journal of Psychiatry, 158*(1), 36-42.

Bateman, A., & Fonagy, P. (2004). *Psychotherapy for borderline personality disorder: Mentalization-based treatment*. Oxford: Oxford University Press.

Bateman, A., & Fonagy, P. (2008a). 8-Year Follow-Up of Patients Treated for Borderline Personality Disorder: Mentalization-Based Treatment Versus Treatment as Usual. [Article]. *American Journal of Psychiatry, 165*(5), 631-638.

Bateman, A., & Fonagy, P. (2008b). Mentalization-Based Treatment for BPD. *Social Work in Mental Health, 6*(1-2), 187-201.

Bateman, A., & Fonagy, P. (2009). Randomized Controlled Trial of Outpatient Mentalization-Based Treatment Versus Structured Clinical Management for Borderline Personality Disorder. *American Journal of Psychiatry, 166*(12), 1355-1364.

Bateman, A., & Fonagy, P. (2010). Mentalization based treatment for borderline personality disorder. *World Psychiatry, 9*(1), 11-15.

Bateman, A., & Fonagy, P. (2012). *Handbook of mentalizing in mental health practice*. Washington, DC: American Psychiatric Publishing, Inc.

Bateman, A., & Fonagy, P. (2013). Mentalization-Based Treatment. *Psychoanalytic Inquiry, 33*(6), 595-613.

Bateman, A. W., & Fonagy, P. (2003). The development of an attachment-based treatment program for borderline personality disorder. *Bulletin of the Menninger Clinic, 67*(3), 187-211.

Batten, S. V., Orsillo, S. M., & Walser, R. D. (2006). Acceptance and mindfulness-based approaches to the treatment of posttraumatic stress disorder. In S. M. Orsillo & L. Roemer (Eds.), *Acceptance and mindfulness-based approaches to anxiety: Conceptualization and treatment* (pp. 241-269). New York, NY: Springer.

Battle, C. L., Shea, M. T., Johnson, D. M., Yen, S., Zlotnick, C., Zanarini, M. C., . . . Morey, L. C. (2004). Childhood maltreatment associated with adult personality disorders: Findings from the collaborative longitudinal personality disorders study. *Journal of Personality Disorders, 18*(2), 193-211.

Beatson, J. (2010). Aetiology of bordeline personality disorder. In J. Beatson, S. Rao & C. Watson (Eds.), *Borderline Personality Disorder: Towards effective treatment* (pp. 17-37). Fitzroy, Australia: Australian Postgraduate Medicine.

Beatson, J., & Rao, S. (2010). Psychotherapy for borderline personality disorder. In J. Beatson, S. Rao & C. Watson (Eds.), *Borderline Personality Disorder: Towards effective treatment* (pp. 125-166). Fitzroy, Australia: Australian Postgraduate Medicine.

Beatson, J., Rao, S., & Watson, C. (2010). *Borderline Personality Disorder: Towards effective treatment*. Fitzroy, Australia: Australian Postgraduate Medicine.

Bender, D. S., Dolan, R. T., Skodol, A. E., Sanislow, C. A., Dyck, I. R., McGlashan, T. H., . . . Gunderson, J. G. (2001). Treatment Utilization by Patients With Personality Disorders. *American Journal of Psychiatry, 158*(2), 295-302.

Benoit, D., & Parker, K. C. H. (1994). Stability and Transmission of Attachment across Three Generations. [Article]. *Child Development, 65*(5), 1444-1456.

Biggerstaff, D., & Thompson, A. R. (2008). Interpretative Phenomenological Analysis (IPA): A Qualitative Methodology of Choice in Healthcare Research. *Qualitative Research in Psychology, 5*, 214-224.

Bland, A. R., Williams, C. A., Scharer, K., & Manning, S. (2004). Emotion processing in borderline personality disorders. *Issues in mental health nursing, 25*(7), 655-672.

Blum, N., Pfohl, B., John, D. S., Monahan, P., & Black, D. W. (2002). STEPPS: A cognitive-behavioral systems-based group treatment for outpatients with borderline personality disorder—a preliminary report. *Comprehensive Psychiatry, 43*(4), 301-310.

Blum, N., St. John, D., Pfohl, B., Stuart, S., McCormick, B., Allen, J., . . . Black, D. W. (2008). Systems Training for Emotional Predictability and Problem Solving (STEPPS) for Outpatients With Borderline Personality Disorder: A Randomized Controlled Trial and 1-Year Follow-Up. *American Journal of Psychiatry, 165*(4), 468-478.

Bögels, S., Hellemans, J., van Deursen, S., Römer, M., & van der Meulen, R. (2014). Mindful Parenting in Mental Health Care: Effects on Parental and Child Psychopathology, Parental Stress, Parenting, Coparenting, and Marital Functioning. *Mindfulness, 5*(5), 536-551.

Bögels, S., Hoogstad, B., van Dun, L., de Schutter, S., & Restifo, K. (2008). Mindfulness Training for Adolescents with Externalizing Disorders and their Parents. *Behavioural and Cognitive Psychotherapy, 36*(02), 193-209.

Bögels, S., Lehtonen, A., & Restifo, K. (2010). Mindful Parenting in Mental Health Care. *Mindfulness, 1*(2), 107-120.

Bohus, M., Haaf, B., Simms, T., Limberger, M. F., Schmahl, C., Unckel, C., . . . Linehan, M. M. (2004). Effectiveness of inpatient dialectical behavioral therapy for borderline personality disorder: a controlled trial. *Behaviour research and therapy, 42*(5), 487-499.

Bohus, M., Haaf, B., Stiglmayr, C., Pohl, U., Bohme, R., & Linehan, M. (2000). Evaluation of inpatient dialectical-behavioral therapy for borderline personality disorder - a prospective study. *Behaviour Research and Therapy, 38*(9), 875-887.

Bornovalova, M. A., Hicks, B. M., Iacono, W. G., & McGue, M. (2009). Stability, change, and heritability of borderline personality disorder traits from adolescence to adulthood: A longitudinal twin study. *Development and Psychopathology, 21*(Special Issue 04), 1335-1353.

Bos, E. H., Van Wel, E. B., Appelo, M. T., & Verbraak, M. J. P. M. (2011). Effectiveness of Systems Training for Emotional Predictability and Problem Solving (STEPPS) for Borderline Personality Problems in a 'Real-World' Sample: Moderation by Diagnosis or Severity? *Psychotherapy and Psychosomatics, 80*(3), 173-181.

Bouvard, M., Vuachet, M., & Marchand, C. (2011). Examination of the screening properties of the Personality Diagnostic Questionnaire-4+ (PDQ-4+) in a non-

clinical sample. [Article]. *Clinical Neuropsychiatry: journal of treatments evaluation, 8*, 151+.

Bowlby, J. (1969/1982). *Attachment and loss: Vol. 1. Attachment*. New York: Basic Books.

Bowlby, J. (1973). *Attachment and loss, Vol 2. Separation: anxiety and anger*. New York: Basic Books.

Bowlby, J. (1980). *Attachment and loss*. New York, NY US: Basic Books.

Bowlby, J. (1988). *A Secure Base*. London: Routledge.

Brach, T. (2003). *Radical acceptance: Embracing your life with the heart of a Buddha*. New York, NY: Bantam.

Bradley, R., Jenei, J., & Westen, D. (2005). Etiology of Borderline Personality Disorder: Disentangling the Contributions of Intercorrelated Antecedents. *The Journal of Nervous and Mental Disease, 193*(1), 24-31.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Brennan, K. A., Clark, C. L., & Shaver, P. R. (1998). Self-report measurement of adult attachment: An integrative overview. In J. A. Simpson & W. S. Rholes (Eds.), *Attachment theory and close relationships* (pp. 46-76). New York: Guilford Press.

Brown, K. W., Ryan, R. A., & Creswell, J. D. (2007). Mindfulness: Theoretical foundations and evidence for its salutary effects. [Review]. *Psychological Inquiry, 18*(4), 211-237.

Brown, T. A., Chorpita, B. F., Korotitsch, W., & Barlow, D. H. (1997). Psychometric properties of the Depression Anxiety Stress Scales (DASS) in clinical samples. *Behaviour Research and Therapy, 35*(1), 79-89.

Busk, P. L., & Marascuilo, L. A. (1992). Statistical analysis in single-case reserach: Issues, procedures, and recommendations, with applicaitons to multiple beahaviors. In T. R. Kratochwill & J. R. Levin (Eds.), *Single-Case Research Design and Analysis: New Directions for Psychology and Education*. Hillsdale, New Jersey: Lawrence Erlbaum Associates.

Calkins, S. D., & Hill, A. (2007). Caregiver influences on emerging emotion regulation: Biological and environmental transactions in early development. In J. J. Gross (Ed.), *Handbook of emotion regulation* (pp. 229-248). New York: Guilford Press.

Campbell, J., Trapnell, P., Heine, S., & Katz, I. (1996). Self-concept clarity: Measurement, personality correlates, and cultural boundaries. *Journal of Personality and Social Psychology, 70*(1), 141.

Carlson, E. A. (1997). *A prospective longitudinal study of consequences of attachment disorganization/disorientation*. Paper presented at the 62nd Meeting of the Society for Research in Child Development, Minneapolis, MN.

Carlson, E. A. (1998). A prospective longitudinal study of attachment disorganization/disorientation. [Article]. *Child Development, 69*(4), 1107.

Carlson, V., Cicchetti, D., Barnett, D., & Braunwald, K. (1989). Disorganized/disoriented attachment relationships in maltreated infants. *Developmental psychology, 25*(4), 525.

Carmody, J., & Baer, R. A. (2008). Relationships between mindfulness practice and levels of mindfulness, medical and psychological symptoms and well-being in a mindfulness-based stress reduction program. *Journal of Behavioral Medicine, 31*(1), 23-33.

Carson, J. W., Carson, K. M., Gil, K. M., & Baucom, D. H. (2004). Mindfulness-based relationship enhancement. [Article]. *Behavior Therapy, 35*(3), 471-494.

Casselman, R. B., & Pemberton, J. R. (2015). ACT-based parenting group for veterans with PTSD: Development and preliminary outcomes. *American Journal of Family Therapy, 43*(1), 57-66.

Cassidy, J. (1994). Emotion regulation: Influences of attachment relationships. *Monographs of the society for research in child development, 59*, 228-249.

Cassidy, J. (2008). The Nature of the Child's Ties. In J. Cassidy (Ed.), *Handbook of Attachment : Theory, Research, and Clinical Applications* (2nd ed., pp. 3-22). New York: Guilford Press.

Cassidy, J., Ziv, Y., Stupica, B., Sherman, L. J., Butler, H., Karfgin, A., . . . Powell, B. (2010). Enhancing attachment security in the infants of women in a jail-diversion program. [Article]. *Attachment & Human Development, 12*(4), 333-353.

Ciarrochi, J., & Bailey, A. (2008). *CBT Practitioner's Guide to ACT: How to Bridge the Gap Between Cognitive Behavioral Therapy and Acceptance and Commitment Therapy*. Oakland, CA: New Harbinger Publications.

Cicchetti, D., Toth, S. L., & Rogosch, F. A. (1999). The efficacy of toddler-parent psychotherapy to increase attachment security in offspring of depressed mothers. *Attachment & Human Development, 1*(1), 34-66.

Clark, L. A., Kochanska, G., & Ready, R. (2000). Mothers' personality and its interaction with child temperament as predictors of parenting behavior. *Journal of Personality and Social Psychology, 79*(2), 274-285.

Coe, M., Dalenberg, C., Aransky, K., & Reto, C. (1995). Adult attachment style, reported childhood violence history and types of dissociative experiences. *Dissociation, 8*, 142-154.

Cohen, J. W. (1988). *Statistical power analysis for the behavioural sciences* (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum Associates.

Cohen, N. J., Lojkasek, M., Muir, E., Muir, R., & Parker, C. J. (2002). Six-month follow-up of two mother-infant psychotherapies: Convergence of therapeutic outcomes. *Infant Mental Health Journal, 23*(4), 361-380.

Cohen, N. J., Muir, E., Lojkasek, M., Muir, R., Parker, C. J., Barwick, M., & Brown, M. (1999). Watch, wait, and wonder: Testing the effectiveness of a new approach to mother–infant psychotherapy. [Article]. *Infant Mental Health Journal, 20*(4), 429-451.

Coid, J., Yang, M., Bebbington, P., Moran, P., Brugha, T., Jenkins, R., . . . Ullrich, S. (2009). Borderline personality disorder: health service use and social functioning among a national household population. *Psychol. Med., 39*(10), 1721-1731.

Coid, J., Yang, M., Tyrer, P., Roberts, A., & Ullrich, S. (2006). Prevalence and correlates of personality disorder in Great Britain. *British Journal of Psychiatry, 188*, 423-431.

Coleman, P. K., & Karraker, K. H. (1998). Self-Efficacy and Parenting Quality: Findings and Future Applications. *Developmental Review, 18*(1), 47-85.

Collins, N. L., Guichard, A. C., Ford, M. B., & Feeney, B. C. (2004). Working models of attachment: New developments and emerging themes. In W. S. Rholes & J. A. Simpson (Eds.), *Adult attachment: Theory, research, and clinical implications* (pp. 196-239). New York: The Guilford Press.

Conklin, C. Z., & Westen, D. (2005). Borderline Personality Disorder in Clinical Practice. *American Journal of Psychiatry, 162*(5), 867-875.

Cooper, G., Hoffman, K. T., & Powell, B. (2003). *The Circle of Security Perinatal Protocol*. Unpublished manuscript. Marycliff Institute.

Cooper, G., Hoffman, K. T., & Powell, B. (2009). *COS-P Facilitator DVD manual 5.0*.

Cozolino, L. (2014). *The Neuroscience of Human Relationships: Attachment and the Developing Social Brain* (2nd ed.). New York: WW Norton & Company.

Crandell, L. E., Patrick, M. P. H., & Hobson, R. P. (2003). 'Still-face' interactions between mothers with borderline personality disorder and their 2-month-old infants. *British Journal of Psychiatry, 183*(Sept.), 239-247.

Crowe, M. (2004). Never good enough – part 1: shame or borderline personality disorder? *Journal of Psychiatric and Mental Health Nursing, 11*(3), 327-334.

Crowell, J. A., Fraley, R. C., & Shaver, P. R. (2008). Measurement of individual differences in adolescent and adult attachment. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications (2nd ed.).* (pp. 599-634). New York, NY US: Guilford Press.

Dekovic, M., Asscher, J., Manders, W., Prins, P., & van Der Laan, P. (2012). Within-Intervention Change: Mediators of Intervention Effects During Multisystemic Therapy. *Journal of Consulting and Clinical Psychology, 80*(4), 574-587.

Dick, A., Niles, B., Street, A., Dimartino, D., & Mitchell, K. (2014). Examining Mechanisms of Change in a Yoga Intervention for Women: The Influence of Mindfulness, Psychological Flexibility, and Emotion Regulation on PTSD Symptoms. *Journal of Clinical Psychology, 70*(12), 1170.

Dickhaut, V., & Arntz, A. (2014). Combined group and individual schema therapy for borderline personality disorder: a pilot study. *Journal of behavior therapy and experimental psychiatry, 45*(2), 242.

Diedrich, A., Grant, M., Hofmann, S. G., Hiller, W., & Berking, M. (2014). Self-compassion as an emotion regulation strategy in major depressive disorder. *Behaviour Research and Therapy, 58*, 43-51.

Donegan, N. H., Sanislow, C. A., Blumberg, H. P., Fulbright, R. K., Lacadie, C., Skudlarski, P., . . . Wexler, B. E. (2003). Amygdala hyperreactivity in borderline personality disorder: implications for emotional dysregulation. *Biological Psychiatry, 54*(11), 1284-1293.

Driessen, M., Herrmann, J., Stahl, K., Zwaan, M., Meier, S., Hill, A., . . . Petersen, D. (2000). Magnetic resonance imaging volumes of the hippocampus and the amygdala in women with borderline personality disorder and early traumatization. *Archives of general psychiatry, 57*(12), 1115-1122.

Duncan, L. G., Coatsworth, J. D., & Greenberg, M. T. (2009). A model of mindful parenting: Implications for parent-child relationships and prevention research. *Clinical Child and Family Psychology Review, 12*(3), 255-270.

Dunn, C., Hanieh, E., Roberts, R., & Powrie, R. (2012). Mindful pregnancy and childbirth: effects of a mindfulness-based intervention on women's psychological distress and well-being in the perinatal period. *Arch. Womens Ment. Health, 15*(2), 139-143.

Eisenberg, N., Cumberland, A., & Spinrad, T. L. (1998). Parental Socialization of Emotion. [Article]. *Psychological Inquiry, 9*(4), 241.

Elices, M., Pascual, J. C., Carmona, C., Martín-Blanco, A., Feliu-Soler, A., Ruiz, E., . . . Soler, J. (2015). Exploring the relation between childhood trauma,

temperamental traits and mindfulness in borderline personality disorder. *BMC psychiatry, 15*, 180.

Emde, R. N. (1980). *Emotional availability: A reciprocal reward system for infants and parents with implications for the prevention of psychosocial disorders.* New York: Pergamon Press.

Ensink, K., & Mayes, L. C. (2010). The development of mentalisation in children from a theory of mind perspective. *Psychoanalytic Inquiry, 30*(4), 301-337.

Fassbinder, E., Hauer, A., Schaich, A., Schweiger, U., Jacob, G. A., & Arntz, A. (2015). Integration of e-Health Tools Into Face-to-Face Psychotherapy for Borderline Personality Disorder: A Chance to Close the Gap Between Demand and Supply? *Journal of Clinical Psychology, 71*(8), 764-777.

Feldman, C., & Kuyken, W. (2011). Compassion in the landscape of suffering. *Contemporary Buddhism, 12*(1), 143-155.

Feldman, R. B., Zelkowitz, P., Weiss, M., Vogel, J., Heyman, M., & Paris, J. (1995). A comparison of the families of mothers with borderline and nonborderline personality disorders. *Comprehensive Psychiatry, 36*(2), 157-163.

Field, A. P. (2009). *Discovering statistics using SPSS* (3rd ed.). London: SAGE.

Field, T. M., & Fox, N. A. (1985). *Social perception in infants*. Norwood, NJ: Ahler.

First, M. B., & Gibbon, M. (2004). The Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) and the Structured Clinical Interview for DSM-IV Axis II Disorders (SCID-II) In M. J. Hilsenroth & A. L. Segal (Eds.), *Comprehensive handbook of psychological assessment* (Vol. 2, pp. 134-143). Hoboken, NJ: John Wiley & Sons.

First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. W. (1997). *Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) - Clinician Version*. Washington, DC: American Psychiatric Press.

First, M. B., Spitzer, R. L., Williams, J. B. W., & Gibbon, M. (1997). *Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II) user's guide and interview*. Washington, D.C.: American Psychiatric Press.

Fischer-Kern, M., Buchheim, A., Hörz, S., Schuster, P., Doering, S., Kapusta, N. D., . . . Buchheim, P. (2010). The relationship between personality organization, reflective functioning, and psychiatric classification in borderline personality disorder. *Psychoanalytic Psychology, 27*(4), 395.

Fisher, S. F. (1985). Identity of two: The phenomenology of shame in borderline development and treatment. *Psychotherapy: Theory, Research, Practice, Training, 22*(1), 101-109.

Flett, G. L., Hewitt, P. L., Oliver, J. M., & Macdonald, S. (2002). Perfectionism in children and their parents: A developmental analysis. In G. L. Flett & P. L. Hewitt (Eds.), *Perfectionism: Theory, research, and treatment* (pp. 89-132). Washington, DC: American Psychological Association.

Follette, V., Palm, K., & Pearson, A. (2006). Mindfulness and trauma: Implications for treatment. *Journal of Rational-Emotive and Cognitive-Behavior Therapy, 24*(1), 45-61.

Fonagy, P. (1991). Thinking about thinking: Some clinical and theoretical considerations in the treatment of a borderline patient. *The International Journal of Psychoanalysis*.

Fonagy, P. (2000). Attachment and borderline personality disorder. *Journal of the American Psychoanalytic Association, 48*(4), 1143-1146.

Fonagy, P., & Bateman, A. (2008). The development of borderline personality disorder - A mentalizing model. [Article]. *Journal of Personality Disorders, 22*(1), 4-21.

Fonagy, P., & Bateman, A. W. (2005). Attachment Theory and Mentalization-Oriented Model of Borderline Personality Disorder. *The American Psychiatric Publishing textbook of personality disorders.*, 187-207.

Fonagy, P., & Bateman, A. W. (2006). Mechanisms of change in mentalization-based treatment of BPD. *Journal of Clinical Psychology, 62*(4), 411-430.

Fonagy, P., Gergely, G., Jurist, E. L., & Target, M. (2002). *Affect regulation, mentalization and the development of the self*. New York: Other Press.

Fonagy, P., Gergely, G., Jurist, E. L., & Target, M. (2004). *Affect Regulation, Mentalization and the Development of the Self*. London: Karnac Books.

Fonagy, P., Gergely, G., & Target, M. (2008). Psychoanalytic Constructs and Attachment Theory and Research. In J. Cassidy (Ed.), *Handbook of Attachment : Theory, Research, and Clinical Applications* (2nd ed., pp. 783-810). New York: Guilford Press.

Fonagy, P., Leigh, T., Steele, M., Steele, H., Kennedy, R., Mattoon, G., . . . Gerber, A. (1996). The relation of attachment status, psychiatric classification, and response to psychotherapy. *Journal of Consulting and Clinical Psychology, 64*(1), 22-31.

Fonagy, P., & Luyten, P. (2009). A developmental, mentalization-based approach to the understanding and treatment of borderline personality disorder. *Development and Psychopathology, 21*, 1355-1381.

Fonagy, P., Luyten, P., & Strathearn, L. (2011). Mentalization and the roots of borderline personality disorder in infancy. In H. E. Fitzgerald, K. Fuura, M. Tomlinson & C. Paul (Eds.), *International perspectives on children and mental health: Development and context* (Vol. 1, pp. 129-154). New York: Praeger.

Fonagy, P., Steele, M., Steele, H., Higgitt, A., & Target, M. (1994). Theory and practice of resilience. *Journal of Child Psychology and Psychiatry and Allied Disciplines, 35*, 231–257.

Fonagy, P., Steele, M., Steele, H., Leigh, T., Kennedy, R., Mattoon, G., & Target, M. (1995). Attachment, the reflective self, and borderline states: The predictive specificity of the Adult Attachment Interview and pathological emotional development. In S. Goldberg, R. Muir & J. Kerr (Eds.), *Attachment theory: Social, developmental, and clinical perspectives* (pp. 233-278). Hillsdale, NJ, US: Analytic Press, Inc.

Fonagy, P., & Target, M. (1997). Attachment and reflective function: Their role in self-organization. *Development and Psychopathology, 9*(4), 679-700.

Fonagy, P., & Target, M. (2000). The place of psychodynamic theory in developmental psychopathology. *Development and Psychopathology, 12*(3), 407-425.

Fonagy, P., Target, M., Gergely, G., Allen, J. G., & Bateman, A. W. (2003). The Development Roots of Borderline Personality Disorder in Early Attachment Relationships: A Theory and Some Evidence. [Article]. *Psychoanalytic Inquiry, 23*(3), 412.

Fonagy, P., Target, M., Gergely, G., Bateman, A. W., & Allen, J. G. (2003). The developmental roots of borderline personality disorder in early attachment relationships: A theory and some evidence. *Psychoanalytic Inquiry, 23*(3), 412-459.

Fonagy, P., Target, M., Steele, H., & Steele, M. (1998). Reflective-functioning manual, version 5.0, for application to adult attachment interviews. *London: University College London*.

Fossati, A., Feeney, J., Maffei, C., & Borroni, S. (2011). Does mindfulness mediate the association between attachment dimensions and Borderline Personality Disorder features? A study of Italian non-clinical adolescents. [Article]. *Attachment & Human Development, 13*(6), 563-578.

Fossati, A., Maffei, C., Bagnato, M., Donati, D., Donini, M., Fiorilli, M., . . . Ansoldi, M. (1998). Brief Communication: Criterion Validity of the Personality Diagnostic Questionnaire-4+ (PDQ-4+) in a Mixed Psychiatric Sample. *Journal of Personality Disorders, 12*(2), 172-178.

Fossati, A., Vigorelli Porro, F., Maffei, C., & Borroni, S. (2012). Are the DSM-IV Personality Disorders Related to Mindfulness? An Italian Study on Clinical Participants. [Article]. *Journal of Clinical Psychology, 68*(6), 672-683.

Fox, C. R., & Gelfand, D. M. (1994). Maternal depressed mood and stress as related to vigilance, self-efficacy and mother-child interactions. *Early Development and Parenting, 3*(4), 233-243.

Gagnon, J., Leblanc, J.-S., & St-Amand, J. (2015). Relationship between Two Dimensions of Object Relations and Group Psychotherapy Attendance Rate in Borderline Personality Disorder Individuals. *Journal of Psychology & Psychotherapy, 5*(2), 1-5.

Galhardo, A., Cunha, M., Pinto-Gouveia, J., & Matos, M. (2013). The Mediator Role of Emotion Regulation Processes on Infertility-Related Stress. [Article]. *Journal of Clinical Psychology in Medical Settings, 20*(4), 497-507.

Gardner, F., Burton, J., & Klimes, I. (2006). Randomised controlled trial of a parenting intervention in the voluntary sector for reducing child conduct problems: outcomes and mechanisms of change. [Article]. *Journal of Child Psychology & Psychiatry, 47*(11), 1123-1132.

Gavita, O. A., DiGiuseppe, R., & David, D. (2013). Self-acceptance and the parenting of children. In M. E. Bernard (Ed.), *The Strength of Self-Acceptance: Theory, Practice and Research* (pp. 193-214). New York: Springer.

Germer, C. K. (2009). *The mindful path to self-compassion: Freeing yourself from destructive thoughts and emotions*. New York: Guilford Press.

Germer, C. K. (2013). Mindfulness: What is it? What does it matter? In P. R. Fulton, C. K. Germer & R. D. Siegel (Eds.), *Mindfulness and psychotherapy* (2nd ed.). New York, NY: The Guilford Press.

Gilbert, P. (2000). Social mentalities: Internal" social'conflict and the role of inner warmth and compassion in cognitive therapy.

Gilbert, P. (2005). *Compassion: Conceptualisations, research and use in psychotherapy*: Routledge.

Gilbert, P. (2009). The Compassionate Mind. London: Constable & Robinson.

Gilbert, P. (2010). *The compassionate mind: A new approach to life's challenges*: New Harbinger Publications.

Gilbert, P., & Procter, S. (2006). Compassionate mind training for people with high shame and self-criticism: overview and pilot study of a group therapy approach. *Clinical Psychology & Psychotherapy, 13*(6), 353-379.

Glaser, D. (2000). Child Abuse and Neglect and the Brain - A Review. [Article]. *Journal of Child Psychology & Psychiatry & Allied Disciplines, 41*(1), 97.

Goodman, M., Carpenter, D., Tang, C. Y., Goldstein, K. E., Avedon, J., Fernandez, N., . . . Hazlett, E. A. (2014). Dialectical behavior therapy alters emotion regulation and amygdala activity in patients with borderline personality disorder. *Journal of Psychiatric Research, 57*, 108-116.

Goodwin, S., & Huppatz, K. (2010). The good mother in theory and research: An overview. In S. Goodwin & K. Huppatz (Eds.), *The good mother: Contemporary motherhoods in Australia*. Sydney, Australia: Sydney University Press.

Goyette-Ewing, M., Slade, A., Knoebber, K., Gilliam, W., Truman, S., & Mayes, L. (2003). *Parents first: A developmental parenting program*. Unpublished manuscript. Yale Child Study Center. New Haven, CT.

Grant, B. F., Chou, S. P., Goldstein, R. B., Huang, B., Stinson, F. S., Saha, T. D., . . . Ruan, W. J. (2008). Prevalence, correlates, disability, and comorbidity of DSM-IV borderline personality disorder: Results from the Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Clinical Psychiatry, 69*(4), 533-545.

Gratz, K. L., & Gunderson, J. G. (2006). Preliminary data on an acceptance-based emotion regulation group intervention for deliberate self-harm among women with borderline personality disorder. *Behav. Therapy, 37*(1), 25-35.

Gratz, K. L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the difficulties in emotion regulation scale. *Journal of Psychopathology and Behavioral Assessment, 26*(1), 41-54.

Gratz, K. L., Rosenthal, M. Z., Tull, M. T., Lejuez, C. W., & Gunderson, J. G. (2010). An experimental investigation of emotional reactivity and delayed emotional recovery in borderline personality disorder: the role of shame. *Comprehensive Psychiatry, 51*(3), 275-285.

Green, J., & Goldwyn, R. (2002). Annotation: Attachment disorganisation and psychopathology: new findings in attachment research and their potential

implications for developmental psychopathology in childhood. [Article]. *Journal of Child Psychology & Psychiatry & Allied Disciplines, 43*(7), 835-846.

Green, J., Stanley, C., Smith, V., & Goldwyn, R. (1999). *The identification of representations of attachment in 5-8 year old children: Validation of a Child Attachment Interview*. Paper presented at the European Science Foundation Workshop, 'Attachment Disorganisation and Psychopathology in Development', Leiden, The Netherlands.

Greyner, B. F. S. (2014). An integrative relational step-down model of care: The Project Air Strategy for Personality Disorders. *The ACPARIAN*(9), 8-13.

Greyner, B. F. S., & Fanaian, M. (2015). *Final report on the treatment of personality disorders research project (2010-2013)*. Wollongong: University of Wollongong, Illawarra Health and Medical Research Institute.

Grienenberger, J., Kelly, K., & Slade, A. (2005). Maternal reflective functioning, mother–infant affective communication, and infant attachment: Exploring the link between mental states and observed caregiving behavior in the intergenerational transmission of attachment. *Attachment & Human Development, 7*(3), 299-311.

Grinker, R. R., Werble, B., & Drye, R. C. (1968). *The borderline syndrome: A behavioral study of ego functions*. New York: Basic Books.

Groth-Marnat, G. (2009). *Handbook of Psychological Assessment* (Fifth ed.). Hoboken, New Jersey: John Wiley & Sons, Inc.

Gunderson, J. G. (1996). The borderline patient's intolerance of aloneness: Insecure attachments and therapist availability. *The American Journal of Psychiatry, 153*(6), 752-758.

Gunderson, J. G., & Singer, M. T. (1975). Defining borderline patients: An overview. *American Journal of Psychiatry, 132*(1), 1-10.

Gunderson, J. G., Stout, R. L., McGlashan, T. H., & et al. (2011). Ten-year course of borderline personality disorder: Psychopathology and function from the collaborative longitudinal personality disorders study. *Archives of General Psychiatry, 68*(8), 827-837.

Gunderson, J. G., Weinberg, I., Daversa, M. T., Kueppenbender, K. D., Zanarini, M. C., Shea, M. T., . . . Dyck, I. (2006). Descriptive and longitudinal observations on the relationship of borderline personality disorder and bipolar disorder. *The American Journal of Psychiatry, 163*(7), 1173-1178.

Gunnar, M. R., Brodersen, L., Nachmias, M., Buss, K., & Rigatuso, J. (1996). Stress reactivity and attachment security. *Developmental Psychobiology, 29*(3), 191-204.

Habermeyer, E., Habermeyer, V., Jahn, K., Domes, G., Nagel, E., & Herpertz, S. C. (2009). An Internet based discussion board for persons with borderline personality disorders moderated health care professionals. *Psychiatrische Praxis, 36*, 23-29.

Harris, R. (2006). Embracing your demons: an overview of acceptance and commitment therapy. *Psychotherapy in Australia, 12*(4), 70-76.

Harris, R. (2007). *The happiness trap: stop struggling, start living*. Wollombi, Australia: Exisle Publishing Limited.

Harris, R. (2009). *ACT made simple*. Oakland, CA: New Harbinger Publications, Inc.

Hawes, D. J., Helyer, R., Herlianto, E. C., & Willing, J. (2013). Borderline Personality Features and Implicit Shame-Prone Self-Concept in Middle Childhood and

Early Adolescence. [Article]. *Journal of Clinical Child & Adolescent Psychology, 42*(3), 302-308.

Hawley, L., Schwartz, D., Bieling, P., Irving, J., Corcoran, K., Farb, N., . . . Segal, Z. (2014). Mindfulness Practice, Rumination and Clinical Outcome in Mindfulness-Based Treatment. [Article]. *Cognitive Therapy & Research, 38*(1), 1-9.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change*. New York: Guilford Press.

Henderson, A., Harmon, S., & Newman, H. (2015). The price mothers pay, even when they are not buying it: Mental health consequences of idealized motherhood. *Sex Roles*, No Pagination Specified.

Herman, J. L. (1992). Complex PTSD: A Syndrome in Survivors of Prolonged and Repeated Trauma. [Article]. *Journal of Traumatic Stress, 5*(3), 377-391.

Herman, J. L., Perry, C., & van der Kolk, B. A. (1989). Childhood trauma in borderline personality disorder. *The American Journal of Psychiatry, 146*(4), 490-495.

Herpertz, S. C., Dietrich, T. M., Wenning, B., Krings, T., Erberich, S. G., Willmes, K., . . . Sass, H. (2001). Evidence of abnormal amygdala functioning in borderline personality disorder: a functional MRI study. *Biological Psychiatry, 50*(4), 292-298.

Hertsgaard, L. M. (1995). Adrenocortical Responses to the Strange Situation in Infants with Disorganized/ Disoriented Attachment Relationships. [Article]. *Child Development, 66*(4), 1100-1106.

Hesse, E., & Main, M. (2000). Disorganized Infant, Child, and Adult Attachment: Collapse in Behavioral and Attentional Strategies. *Journal of the American Psychoanalytic Association, 48*(4), 1097-1127.

Hill, C. L. M., & Updegraff, J. A. (2012). Mindfulness and Its Relationship to Emotional Regulation. *Emotion, 12*(1), 81-90.

Hobson, R. P., Patrick, M., Crandell, L., Garcia-Perez, R., & Lee, A. (2005). Personal relatedness and attachment in infants of mothers with borderline personality disorder. *Development and Psychopathology, 17*(2), 329-347.

Hofer, M. A. (1994). Hidden regulators in attachment, separation, and loss. *Monographs of the Society for Research in Child Development, 59*(2-3), 192-207.

Hoffman, K. T., Marvin, R. S., Cooper, G., & Powell, B. (2006). Changing toddlers' and preschoolers' attachment classifications: The circle of security intervention. *Journal of Consulting and Clinical Psychology, 74*(6), 1017-1026.

Holman, S. L. (1985). A group program for borderline mothers and their toddlers. *International Journal of Group Psychotherapy, 35*(1), 79-93.

Holmes, J. (2003). Borderline personality disorder and the search for meaning: an attachment perspective. [Article]. *Australian & New Zealand Journal of Psychiatry, 37*(5), 524-531.

Holmes, J. (2004). Disorganized attachment and Borderline Personality Disorder: A clinical perspective. *Attachment & Human Development, 6*(2), 181-190.

Holmes, T. H., & Rahe, R. H. (1967). The social readjustment rating scale. *Journal of Psychosomatic Research, 11*(2), 213-218.

Hölzel, B. K., Lazar, S. W., Gard, T., Schuman-Olivier, Z., Vago, D. R., & Ott, U. (2011). How Does Mindfulness Meditation Work? Proposing Mechanisms of

Action From a Conceptual and Neural Perspective. *Perspectives on Psychological Science, 6*(6), 537-559.

Hooley, J. M., Cole, S. H., & Gironde, S. (2012). Borderline Personality Disorder. In T. A. Widiger (Ed.), *The Oxford Handbook of Personality Disorders* (pp. 409-436). New York: Oxford University Press.

Horton, E., & Murray, C. (2015). A quantitative exploratory evaluation of the circle of security-parenting program with mothers in residential substance-abuse treatment. *Infant mental health journal, 36*(3), 320.

Huang, J., Napolitano, L. A., Wu, J., Yang, Y., Xi, Y., Li, Y., & Li, K. (2014). Childhood experiences of parental rearing patterns reported by Chinese patients with borderline personality disorder. [Article]. *International Journal of Psychology, 49*(1), 38-45.

Hurt, S. W., Hyler, S. E., Frances, A., Clarkin, J. F., & Brent, R. (1984). Assessing borderline personality disorder with self-report, clinical interview, or semistructured interview. *The American Journal Of Psychiatry, 141*(10), 1228-1231.

Hyler, S. E. (1994). *Personality Questionnaire, PDQ-4+*. New York: New York State Psychiatric Institute.

Hyler, S. E., Skodol, A. E., Kellman, H. D., Oldham, J. M., & Rosnick, L. (1990). Validity of the Personality Diagnostic Questionnaire-Revised: Comparison with two structured interviews. *The American Journal of Psychiatry, 147*(8), 1043-1048.

ICF International. (2010). *Evaluation of the national child traumatic stress initiative: FY 2010 Annual Progress Report, Executive Summary*.

Jackson, A. P., & Huang, C. C. (2000). Parenting Stress and Behavior Among Single Mothers of Preschoolers: The Mediating Role of Self-Efficacy. [Article]. *Journal of Social Service Research, 26*(4), 29-42.

Jackson, H. J. B. P. M. (2000). Personality disorders in the community: a report from the Australian National Survey of Mental Health and Wellbeing. [Article]. *Social Psychiatry & Psychiatric Epidemiology, 35*(12), 531.

Johnson, D. M., Shea, M. T., Yen, S., Battle, C. L., Zlotnick, C., Sanislow, C. A., . . . Zanarini, M. C. (2003). Gender differences in borderline personality disorder: findings from the collaborative longitudinal personality disorders study. *Comprehensive Psychiatry, 44*(4), 284-292.

Jørgensen, C. R., Kjølbye, M., Freund, C., Bøye, R., Jordet, H., & Andersen, D. (2009). Level of functioning in patients with borderline personality disorder. The Risskov-I study. *Nordic Psychology, 61*(1), 42-60.

Jovev, M., & Jackson, H. J. (2006). The relationship of borderline personality disorder, life events adn functioning in an Australian psychiatric sample. *Journal of Personality Disorders, 20*(3), 205-217.

Judge, L., Cleghorn, A., McEwan, K., & Gilbert, P. (2012). An exploration of group-based compassion focused therapy for a heterogeneous range of clients presenting to a community mental health team. *International Journal of Cognitive Therapy, 5*(4), 420-429.

Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: Past, present, and future. [Article]. *Clinical Psychology-Science and Practice, 10*(2), 144-156.

Kaufman, G. (1989). *The psychology of shame*. New York, NY: Springer.

Kaufman, J., & Charney, D. (2001). Effects of early stress on brain structure and function: Implications for understanding the relationship between child

maltreatment and depression. *Development and Psychopathology, 13*(03), 451-471.

Kelly, A. C., Carter, J. C., & Borairi, S. (2014). Are improvements in shame and self-compassion early in eating disorders treatment associated with better patient outcomes? [Article]. *International Journal of Eating Disorders, 47*(1), 54-64.

Kernberg, O. (1967). Borderline personality organization. *Journal of the American Psychoanalytic Association, 15*(3), 641-685.

Kernberg, O. F. (1985). *Borderline conditions and pathological narcissism*. New York: Rowman & Littlefield.

Kinniburgh, K. J. L., Blaustein, M. P., Spinazzola, J. P., & van der Kolk, B. A. M. D. (2005). Attachment, Self-Regulation, and Competency. *Psychiatric Annals, 35*(5), 424-430.

Kliem, S., Kröger, C., & Kosfelder, J. (2010). Dialectical behavior therapy for borderline personality disorder: A meta-analysis using mixed-effects modeling. *Journal of Consulting and Clinical Psychology, 78*(6), 936-951.

Kobak, R., & Madsen, S. (2008). Disruptions in attachment bonds: Implications for theory, research, and clinical intervention. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of Attachment: Theory, Research, and Clinical Applications* (2nd ed., pp. 23-47). New York: Guilford Publications.

Koons, C. R., Robins, C. J., Tweed, J., Lynch, T., Gonzalez, A., Morse, J., . . . Butterfield, M. (2001). Efficacy of dialectical behavior therapy in women veterans with borderline personality disorder. *Behavior Therapy, 32*(2), 371-390.

Krane, V., Andersen, M., & Strean, W. B. (1997). Issues of qualitative research method and presentation. *Journal of Sport and Exercise Psychology, 19*, 213-218.

Kranzler, H. R., Kadden, R. M., Babor, T. F., Tennen, H., & Rounsaville, B. J. (1996). Validity of the SCID in substance abuse patients. *Addiction, 91*(6), 859-868.

Krawitz, R. (2012). Behavioural treatment of severe chronic self-loathing in people with borderline personality disorder. Part 2: Self-compassion and other interventions. *Australasian Psychiatry*.

Kroger, C., Schweiger, U., Sipos, V., Arnold, R., Kahl, K., Schunert, T., . . . Reinecker, H. (2006). Effectiveness of dialectical behaviour therapy for borderline personality disorder in an inpatient setting. *Behav. Res. Ther., 44*(8), 1211-1217.

Lamb, M. E. (1976). Effects of stress and cohort on mother- and father-infant interaction. *Developmental Psychology, 12*(5), 435-443.

Lamb, M. E. (1997). *The Role of the father in child development* (3rd ed.). New York: Wiley.

Lamont, A. (2006). Mothers with borderline personality disorder. *Graduate Student Journal of Psychology, 8*(1), 39-43.

Leerkes, E. M., Blankson, A. N., & O'Brien, M. (2009). Differential Effects of Maternal Sensitivity to Infant Distress and Nondistress on Social-Emotional Functioning. *Child Development, 80*(3), 762-775.

Leichsenring, F., Leibing, E., Kruse, J., New, A., & Leweke, F. (2011). Borderline personality disorder. *Lancet, 377*, 74-84.

Lenzenweger, M., Lane, M. C., Loranger, A., & Kessler, R. C. (2007). DSM-IV personality disorders in the National Comorbidity Survey Replication. *Biol. Psychiatry, 62*(6), 553-564.

Levy, K., Beeney, J., & Temes, C. (2011). Attachment and its Vicissitudes in Borderline Personality Disorder. *Current Psychiatry Reports, 13*(1), 50-59.

Levy, K., Meehan, K., Kelly, K., & Reynoso, J. (2006). Change in Attachment Patterns and Reflective Function in a Randomized Control Trial of Transference-Focused Psychotherapy for Borderline Personality Disorder. *Journal of Consulting and Clinical Psychology, 74*(6), 1027.

Levy, K. N. (2005). The implications of attachment theory and research for understanding borderline personality disorder. *Development and Psychopathology, 17*(4), 959-986.

Levy, K. N., Meehan, K. B., Kelly, K. M., Reynoso, J. S., Weber, M., Clarkin, J. F., & Kernberg, O. F. (2006). Change in attachment patterns and reflective function in a randomized control trial of transference-focused psychotherapy for borderline personality disorder. *Journal of Consulting and Clinical Psychology, 74*(6), 1027-1040.

Lewis, H. (1971). *Shame and guilt in neurosis*. New York: International Universities Press.

Lewis, M. (1995). *Shame: The Exposed Self*. New York: The Free Press.

Lewis, R. J., Griffin, J. L., Winstead, B. A., Morrow, J. A., & Schubert, C. P. (2003). Psychological Characteristics of Women Who Do or Do Not Report a History of Sexual Abuse. *Journal of Prevention & Intervention in the Community, 26*(1), 49-65.

Lieberman, A., & Van Horn, P. (2005). *Don't hit my mommy!: A manual for child-parent psychotherapy with young witnesses of family violence*. Washington DC: Zero to Three Press.

Lieberman, A. F., Van Horn, P., & Ippen, C. G. (2005). Toward Evidence-Based Treatment: Child-Parent Psychotherapy with Preschoolers Exposed to Marital

Violence. *Journal of the American Academy of Child & Adolescent Psychiatry, 44*(12), 1241-1248.

Lindenboim, N., Comtois, K. A., & Linehan, M. M. (2007). Skills Practice in Dialectical Behavior Therapy for Suicidal Women Meeting Criteria for Borderline Personality Disorder. *Cognitive and Behavioral Practice, 14*(2), 147-156.

Linehan, M. (1993a). *Cognitive behavioral treatment of borderline personality disorder*. New York: Guilford Press.

Linehan, M. (1993b). *Skills training manual for treating borderline personality disorder*. New York: Guilford Press.

Linehan, M. M. (1989). Cognitive and behavior therapy for borderline personality disorder. *Review of psychiatry, 8*, 84-102.

Linehan, M. M., Armstrong, H. E., Suarez, A., Allmon, D., & Heard, H. L. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of general psychiatry, 48*(12), 1060-1064.

Linehan, M. M., Korslund, K. E., Harned, M. S., Gallop, R. J., Lungu, A., Neacsiu, A. D., . . . Murray-Gregory, A. M. (2015). Dialectical behavior therapy for high suicide risk in individuals with borderline personality disorder: A randomized clinical trial and component analysis. *JAMA Psychiatry, 72*(5), 475-482.

Linehan, M. M., Schmidt, H., Dimeff, L., Craft, J., Kanter, J., & Comtois, K. (1999). Dialectical Behavior Therapy for patients with borderline personality disorder and drug-dependence. *American Journal of Addiction, 8*(4), 279-292.

Linehan, M. M., Tutek, D., Heard, H. L., & Armstrong, H. (1994). Interpersonal outcome of cognitive behavioral treatment for chronically suicidal borderline patients. *American Journal of Psychiatry, 151*(12), 1771-1776.

Liotti, G. (2000). Disorganized attachment, models of borderline states and evolutionary psychotherapy. In P. Gilbert & K. G. Bailey (Eds.), *Genes on the Couch: Explorations in Evolutionary Psychotherapy* (pp. 232-256). New York: Brunner-Routledge.

Liotti, G. (2013). Disorganised Attachment in the Pathogenesis and the Psychotherapy of Borderline Personality Disorder. *Attachment Theory in Adult Mental Health: A Guide to Clinical Practice*, 113-128.

Liotti, G. (2014). Disorganized attachment, models of borderline states and evolutionary psychotherapy. In P. Gilbert & K. G. Bailey (Eds.), *Genes on the Couch: Explorations in evolutionary psychotherapy* (pp. 232-256). Hoboken, NJ: Taylor and Francis.

Lobbestael, J., Leurgans, M., & Arntz, A. (2011). Inter-rater reliability of the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID I) and Axis II Disorders (SCID II). [Article]. *Clinical Psychology & Psychotherapy, 18*(1), 75-79.

Lovibond, P. F., & Lovibond, S. H. (1995). The structure of negative emotional states: Comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. *Behaviour Research and Therapy, 33*(3), 335-343.

Lovibond, S. H., & Lovibond, P. F. (2004). *Manual for the Depression Anxiety Stress Scales* (2nd ed.). Sydney, Australia: Psychology Foundation Monograph.

Lucre, K. M., & Corten, N. (2013). An exploration of group compassion-focused therapy for personality disorder. [Article]. *Psychology & Psychotherapy: Theory, Research & Practice, 86*(4), 387-400.

Luyten, P., Fonagy, P., Lowyck, B., & Vermote, R. (2012). The assessment of mentalization. In A. Bateman & P. Fonagy (Eds.), *Mentalizing in mental health practice*. Washington, DC: American Psychiatric Association.

Luyten, P., Mayes, L., Njissens, L., & Fonagy, P. (2014). The Parental Reflective Functioning Questionnaire: Development and preliminary validation. *Manuscript submitted for publication*.

Luyten, P., Mayes, L., Sadler, L., Fonagy, P., Nicholls, S., & Crowley, M. *The Parental Reflective Functioning Questionnaire - 1 (PRFQ-1)*. Unpublished manuscript.

Lynch, T. R., Chapman, A. L., Rosenthal, M. Z., Kuo, J. R., & Linehan, M. M. (2006). Mechanisms of change in dialectical behavior therapy: Theoretical and empirical observations. [Article]. *Journal of Clinical Psychology, 62*(4), 459-480.

Lyons-Ruth, K. (1996). Attachment relationships among children with aggressive behavior problems: The role of disorganized early attachment patterns. *Journal of Consulting and Clinical Psychology, 64*(1), 64-73.

Lyons-Ruth, K., Bronfman, E., & Parsons, E. (1999). Maternal frightened, frightening, or atypical behavior and disorganized infant attachment patterns. *Monographs of the Society for Research in Child Development*, 67-96.

Lyons-Ruth, K., Easterbrooks, M. A., & Cibelli, C. D. (1997). Infant attachment strategies, infant mental lag, and maternal depressive symptoms: Predictors of internalizing and externalizing problems at age 7. *Developmental Psychology, 33*(4), 681-692.

Lyons-Ruth, K., & Jacobvitz, D. (1999). Attachment disorganization: Unresolved loss, relational violence, and lapses in behavioral and attentional strategies. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (2nd ed., pp. 520-554). New York: Guilford.

Macfie, J., & Swan, S. A. (2009). Representations of the caregiver–child relationship and of the self, and emotion regulation in the narratives of young children whose mothers have borderline personality disorder. *Development and Psychopathology, 21*(3), 993-1011.

Madigan, S., Bakermans-Kranenburg, M., Van Ijzendoorn, M., Moran, G., Pederson, D., & Benoit, D. (2006). Unresolved states of mind, anomalous parental behavior, and disorganized attachment: A review and meta-analysis of a transmission gap. *Attach. Hum. Dev., 8*(2), 89-111.

Main, M., & Hesse, E. (1990). Parents' unresolved traumatic experiences are related to infant disorganized attachment status: Is frightened and/or frightening parental behavior the linking mechanism? In M. T. Greenberg, D. Cicchetti & E. M. Cummings (Eds.), *Attachment in the preschool years: Theory, research, and intervention* (pp. 161-182). Chicago: Chicago University Press.

Main, M., Kaplan, N., & Cassidy, J. (1985). Security in Infancy, Childhood, and Adulthood: A Move to the Level of Representation. *Monographs of the Society for Research in Child Development, 50*, 66-104.

Main, M., & Morgan, H. (1996). Disorganization and disorientation in infant strange situation behavior: Phenotypic resemblance to dissociative states. In L. Michelson & W. Ray (Eds.), *Handbook of dissociation* (pp. 107-138). New York: Plenum Press.

Main, M., & Solomon, J. (1986). Discovery of an insecure-disorganized/disoriented attachment pattern. In T. B. Brazelton & M. W. Yogman (Eds.), *Affective development in infancy* (pp. 95-124). Norwood, NJ: Ablex.

Main, M., & Solomon, J. (1990). Procedures for identifying infants as disorganized/disoriented during the Ainsworth Strange Situation. In M. T.

Greenberg, D. Cicchetti & E. M. Cummings (Eds.), *Attachment in the preschool years: Theory, research, and intervention* (Vol. 1, pp. 121-160). Chicago: Chicago University Press.

Makela, E. H., Moeller, K. E., Fullen, J. E., & Gunel, E. (2006). Medication Utilization Patterns and Methods of Suicidality in Borderline Personality Disorder. *Annals of Pharmacotherapy, 40*(1), 49-52.

Malatesta, C. Z., Culver, C., Tesman, J. R., Shepard, B., Fogel, A., Reimers, M., & Zivin, G. (1989). The development of emotion expression during the first two years of life. *Monographs of the Society for Research in Child Development*, i-136.

Mangelsdorf, S., Gunnar, M., Kestenbaum, R., Lang, S., & Andreas, D. (1990). Infant Proneness-to-Distress Temperament, Maternal Personality, and Mother-Infant Attachment: Associations and Goodness of Fit. *Child Development, 61*(3), 820.

Marascuilo, L. A., & Serlin, R. C. (1988). *Statistical methods for the social and behavioral science*. New York: W. H. Freeman.

Marvin, R., Cooper, G., Hoffman, K., & Powell, B. (2002). The Circle of Security project: Attachment-based intervention with caregiver-pre-school child dyads. [Article]. *Attachment & Human Development, 4*(1), 107-124.

McCown, D., Reibel, D., & Micozzi, M. S. (2010). *Teaching Mindfulness: A Practical Guide for Clinicians and Educators*. New York: Springer.

McElwain, N. L., & Booth-LaForce, C. (2006). Maternal sensitivity to infant distress and nondistress as predictors of infant-mother attachment security. *Journal of Family Psychology, 20*(2), 247-255.

McGlashan, T. H., Grilo, C. M., Sanislow, C. A., Ralevski, E., & et al. (2005). Two-Year Prevalence and Stability of Individual DSM-IV Criteria for Schizotypal,

Borderline, Avoidant, and Obsessive-Compulsive Personality Disorders: Toward a Hybrid Model of Axis II Disorders. *The American Journal of Psychiatry, 162*(5), 883-889.

McGlashan, T. H., Grilo, C. M., Skodol, A. E., Gunderson, J. G., Shea, M. T., Morey, L. C., . . . Stout, R. L. (2000). The Collaborative Longitudinal Personality Disorders Study: baseline Axis I/II and II/II diagnostic co-occurrence. [Article]. *Acta Psychiatrica Scandinavica, 102*(4), 256-264.

Mental Health Council of Australia, Brain and Mind Institute, & Human Rights and Equal Opportunity Commission. (2005). *Not for service: experiences of injustice and despair in mental health care in Australia*. Canberra: Mental Health Council of Australia.

Mesulam, M. M. (1998). From sensation to cognition. *Brain, 121*, 1013-1052.

Mikulincer, M., Dolev, T., & Shaver, P. (2004). Attachment-related strategies during thought suppression: Ironic rebounds and vulnerable self-representations. *Journal of Personality and Social Psychology, 87*(6), 940-956.

Mikulincer, M., & Shaver, P. R. (2003). The attachment behavioral system in adulthood: Activation, psychodynamics, and interpersonal processes. In M. P. Zanna (Ed.), *Advances in experimental social psychology* (Vol. 35, pp. 53-152). New York: Academic Press.

Mikulincer, M., & Shaver, P. R. (2004). Security-based self-representations in adulthood: Contents and processes. In W. S. Rholes & J. A. Simpson (Eds.), *Adult attachment: Theory, research, and clinical implications* (pp. 159-195). New York: The Guilford Press.

Mikulincer, M., & Shaver, P. R. (2007). *Attachment in adulthood: structure, dynamics, and change*. London: Guilford Press.

Millon, T. (2000). Sociocultural conceptions of the borderline personality. *Psychiatric Clinics of North America, 23*(1), 123-136.

Moreira, H., Gouveia, M., Carona, C., Silva, N., & Canavarro, M. (2015). Maternal Attachment and Children's Quality of Life: The Mediating Role of Self-compassion and Parenting Stress. *Journal of Child and Family Studies, 24*(8), 2332-2344.

Morton, J., & Shaw, L. (2012). *Wise Choices: Acceptance and commitment therapy groups for people with borderline personality disorder*. Melbourne: Australian Postgraduate Medicine.

Morton, J., Snowdon, S., Gopold, M., & Guymer, E. (2012). Acceptance and Commitment Therapy Group Treatment for Symptoms of Borderline Personality Disorder: A Public Sector Pilot Study. *Cognitive and Behavioral Practice, 19*(4), 527-544.

Mosquera, D., Gonzalez, A., & Leeds, A. M. (2014). Early experience, structural dissociation, and emotional dysregulation in borderline personality disorder: the role of insecure and disorganized attachment. [Report]. *Borderline Personality Disorder and Emotion, 1*, 15.

Moss, E., Rousseau, D., Parent, S., St-Laurent, D., & Saintonge, J. (1998). Correlates of attachment at school age: Maternal reported stress, mother-child interaction, and behavior problems. *Child Dev., 69*(5), 1390-1405.

Muir, E., Lojkasek, M., & Cohen, N. J. (1999). *Watch, wait, and wonder: A manual describing a dyadic infant led approach to problems in infancy and early childhood*. Toronto, ON: The Hincks-Dellcrest Centre and The Hincks-Dellcrest Institute.

Munroe-Blum, H., & Marziali, E. (1995). A Controlled Trial of Short-Term Group Treatment for Borderline Personality Disorder. *Journal of Personality Disorders, 9*(3), 190-198.

Muzik, M., Rosenblum, K., Alfafara, E., Schuster, M., Miller, N., Waddell, R., & Kohler, E. (2015). Mom Power: preliminary outcomes of a group intervention to improve mental health and parenting among high-risk mothers. *Official Journal of the Section on Women's Health of the World Psychiatric Association, 18*(3), 507-521.

National Health and Medical Research Council. (2013). *Clinical Practice Guideline for the Management of Borderline Personality Disorder*. Melbourne: National Health and Medical Research Council.

National Institute for Health and Clinical Excellence. (2009). *Borderline Personality Disorder: Treatment and Management. NICE Clinical Guideline 78*. United Kingdom: NICE.

Neacsiu, A. D., Lungu, A., Harned, M. S., Rizvi, S. L., & Linehan, M. M. (2014). Impact of dialectical behavior therapy versus community treatment by experts on emotional experience, expression, and acceptance in borderline personality disorder. *Behaviour Research and Therapy, 53*, 47-54.

Neacsiu, A. D., Rizvi, S. L., & Linehan, M. M. (2010). Dialectical behavior therapy skills use as a mediator and outcome of treatment for borderline personality disorder. *Behaviour Research and Therapy, 48*(9), 832-839.

Neff, K. D., & Faso, D. J. (2015). Self-Compassion and Well-Being in Parents of Children with Autism. *Mindfulness, 6*(4), 938.

Nehls, N. (1998). Borderline personality disorder: gender stereotypes, stigma, and limited system of care. *Issues in Mental Health Nursing, 19*, 97-112.

Newman, L. (2008). Trauma and Ghosts in the Nursery. In A. S. Williams & V. Cowling (Eds.), *Infants of Parents with Mental Illness: Developmental, Clinical, Cultural and Personal Perspectives* (pp. 212-227). Bowen Hills: Australian Academic Press.

Newman, L., & Stevenson, C. (2005). Parenting and Borderline Personality Disorder: Ghosts in the Nursery. *Clinical Child Psychology and Psychiatry, 10*(3), 385-394.

Newman, L., & Stevenson, C. (2008). Issues in infant--parent psychotherapy for mothers with borderline personality disorder. *Clinical child psychology and psychiatry, 13*(4), 505-514.

Newman, L. K., Stevenson, C., Bergman, L. R., & Boyce, P. (2007). Borderline personality disorder, mother-infant interaction and parenting perceptions: Preliminary findings. *Australian and New Zealand Journal of Psychiatry, 41*(7), 598-605.

Nicastro, R., Jermann, F., Bondolfi, G., & McQuillan, A. (2010). Assessment of Mindfulness With the French Version of the Kentucky Inventory of Mindfulness Skills in Community and Borderline Personality Disorder Samples. *Assessment, 17*(2), 197-205.

Nijssens, L., Luyten, P., & Bales, D. L. (2013). Mentalization-based treatment for parents (MBT-P) with borderline personality disorder and their infants. In N. Midgley & I. Vrouva (Eds.), *Minding the child: Mentalization-based interventions with children, young people and their families* (pp. 79-97). New York: Taylor & Francis.

Nose, M., Cipriani, A., Biancosino, B., Grassi, L., & Barbui, C. (2006). Efficacy of pharmacotherapy against core traits of borderline personality disorder: meta-

analysis of randomized controlled trials. *International Clinical Psychopharmacology, 21*(6), 345-353.

Nunes, P. M., Wenzel, A., Borges, K. T., Porto, C. R., Caminha, R. M., & de Oliveira, I. R. (2009). Volumes of the hippocampus and amygdala in patients with borderline personality disorder: a meta-analysis. *Journal of personality disorders, 23*(4), 333-345.

O'Toole, S., Diddy, E., & Kent, M. (2012). Mindfulness and Emotional Well-being in Women with Borderline Personality Disorder. *Mindfulness, 3*(2), 117-123.

Paris, J. (1998). Personality disorders in sociocultural perspective. *Journal of Personality Disorders, 12*(4), 289-301.

Paris, J. (1999). Borderline personality disorder. In P. Millon, P. H. Blaney & R. D. Davies (Eds.), *Oxford textbook of psychopathology* (pp. 628-652). New York: Oxford University Press.

Paris, J. (2005a). Borderline personality disorder. *CMAJ : Canadian Medical Association Journal, 172*(12), 1579-1583.

Paris, J. (2005b). Recent Advances in the Treatment of Borderline Personality Disorder. [Article]. *Canadian Journal of Psychiatry, 50*(8), 435-441.

Paris, J., Zweig-Frank, H., & Guzder, J. (1994). Psychological risk factors for borderline personality disorder in female patients. *Comprehensive Psychiatry, 35*(4), 301-305.

Patrick, M., Hobson, R. P., Castle, D., Howard, R., & Maughan, B. (1994). Personality disorder and the mental representation of early social experience. *Development and Psychopathology, 6*, 375-375.

Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage.

Perroud, N., Nicastro, R., Jermann, F., & Huguelet, P. (2012). Mindfulness skills in borderline personality disorder patients during dialectical behavior therapy: Preliminary results. [Article]. *International Journal of Psychiatry in Clinical Practice, 16*(3), 189-196.

Peters, J. R., Geiger, P. J., Smart, L. M., & Baer, R. A. (2014). Shame and borderline personality features: The potential mediating role of anger and anger rumination. *Personality disorders, 5*(1), 1.

Pfohl, B., Blum, N., St. John, D., McCormick, B., Allen, J., & Black, D. W. (2009). Reliability and validity of the Borderline Evaluation of Severity Over Time (BEST): A self-rated scale to measure severity and change in persons with borderline personality disorder. *Journal of Personality Disorders, 23*(3), 281-293.

Pompili, M., Girardi, P., Ruberto, A., & Tatarelli, R. (2005). Suicide in borderline personality disorder: a meta-analysis. *Nord J Psychiatry, 59*, 319-324.

Project Air Strategy for Personality Disorders. (2015a). *Parenting with Personality Disorder Intervention: A manual for health professionals*. Wollongong: University of Wollongong, Illawarra Health and Medical Research Institute.

Project Air Strategy for Personality Disorders. (2015b). Project Air Strategy Parenting Program - Overview, from http://ihmri.uow.edu.au/content/groups/public/@web/@ihmri/documents/doc/uow195303.pdf

Project Air Strategy for Personality Disorders. (2015c). *Treatment guidelines for personality disorders* (2nd ed.): NSW Health and Illawarra Health and Medical Research Institute.

Putnam, S. P., Sanson, A. V., & Rothbart, M. K. (2002). Child temperament and parenting. In D. M. Brodzinsky, M. H. Bornstein & W. A. Collins (Eds.), *Handbook of Parenting* (pp. 255-278). New Jersey: Lawrence Erlbaum Associates.

Rao, S. (2010a). Biological Treatments. In J. Beatson, S. Rao & C. Watson (Eds.), *Borderline Personality Disorder: Towards effective treatment* (pp. 87-124). Fitzroy, Australia: Australian Postgraduate Medicine.

Rao, S. (2010b). Diagnosing borderline personality disorder. In J. Beatson, S. Rao & C. Watson (Eds.), *Borderline Personality Disorder: Towards effective treatment* (pp. 39-74). Fitzroy, Australia: Australian Postgraduate Medicine.

Reichborn-Kjennerud, T., Czajkowski, N., Ystrøm, E., Ørstavik, R., Aggen, S. H., Tambs, K., . . . Kendler, K. S. (2015). A longitudinal twin study of borderline and antisocial personality disorder traits in early to middle adulthood. *Psychological medicine, 45*(14), 3121.

Reinelt, E., Stopsack, M., Aldinger, M., Ulrich, I., Grabe, H. J., & Barnow, S. (2013). Longitudinal Transmission Pathways of Borderline Personality Disorder Symptoms: From Mother to Child? *Psychopathology, 47*(1), 10-16.

Retzinger, S. M. (1987). Resentment and laughter: Video studies of the shame-rage spiral *The role of shame in symptom formation* (pp. 151-181). Hillsdale, NJ, England: Lawrence Erlbaum Associates, Inc.

Reynolds, D. (2003). Mindful Parenting: a group approach to enhancing reflective capacity in parents and infants. *Journal of Child Psychotherapy, 29*(3), 357 - 374.

Rinne, T., Westenberg, H. G. M., den Boer, J. A., & van den Brink, W. (2000). Serotonergic blunting to meta-chlorophenylpiperazine (m-CPP) highly

correlates with sustained childhood abuse in impulsive and autoaggressive female borderline patients. *Biological Psychiatry, 47*(6), 548-556.

Rizvi, S. L. (2004). *Treatment of Shame in Borderline Personality Disorder.* Doctoral dissertation, University of Washington. Retrieved from https://digital.lib.washington.edu/researchworks/handle/1773/9125.

Roepke, S., Schröder-Abé, M., Schütz, A., Jacob, G., Dams, A., Vater, A., . . . Lammers, C.-H. (2011). Dialectic behavioural therapy has an impact on self-concept clarity and facets of self-esteem in women with borderline personality disorder. *Clinical Psychology & Psychotherapy, 18*(2), 148-158.

Roepke, S., Schröder-Abé, M., Schütz, A., Jacob, G., Dams, A., Vater, A., . . . Lammers, C. H. (2011). Dialectic behavioural therapy has an impact on self-concept clarity and facets of self-esteem in women with borderline personality disorder. *Clinical psychology & psychotherapy, 18*(2), 148-158.

Rogers, C. R. (1961). *On Becoming a Person: A Therapist's View of Psychotherapy: by Carl R. Rogers*. New York: Houghton Mifflin.

Rogers, R. (2001). *Handbook of diagnostic and structured interviewing*. New York: Guilford.

Rosenthal, M. Z., Cheavens, J. S., Lejuez, C. W., & Lynch, T. R. (2005). Thought suppression mediates the relationship between negative affect and borderline personality disorder symptoms. *Behaviour Research and Therapy, 43*(9), 1173-1185.

Rüsch, N., Lieb, K., Göttler, I., Hermann, C., & et al. (2007). Shame and Implicit Self-Concept in Women With Borderline Personality Disorder. *The American Journal of Psychiatry, 164*(3), 500-508.

Sabo, A. N. (1997). Etiological Significance of Associations Between Childhood Trauma and Borderline Personality Disorder: Conceptual and Clinical Implications. *Journal of Personality Disorders, 11*(1), 50-70.

Sadler, L., Slade, A., & Mayes, L. (2006). Minding the baby: A mentalization-based parenting program. In J. G. Allen & P. Fonagy (Eds.), *Handbook of mentalization-based treatment* (pp. 271-288). Chichester, England: John Wiley & Sons Ltd.

Sadler, L. S., Slade, A., Close, N., Webb, D. L., Simpson, T., Fennie, K., & Mayes, L. C. (2013). Minding the Baby: Enhancing Reflectiveness to Improve Early Health and Relationship Outcomes in an Interdisciplinary Home-Visiting Program. [Article]. *Infant Mental Health Journal, 34*(5), 391-405.

Sanders, M. R., & Woolley, M. (2005). The relationship between maternal self-efficacy and parenting practices: Implications for parent training. *Child: care, health and development, 31*(1), 65-73.

Saulsman, L. M., & Page, A. C. (2004). The five-factor model and personality disorder empirical literature: A meta-analytic review. *Clinical Psychology Review, 23*(8), 1055-1085.

Schacht, R. L. M. B. S. (2013). The Relation between Mind-mindedness in Mothers with Borderline Personality Disorder and Mental State Understanding in their Children. [Article]. *Infant & Child Development, 22*(1), 68-84.

Schmideberg, M. (1947). The treatment of psychopaths and borderline patients. *American Journal of Psychotherapy, 1*, 45-55.

Schore, A. N. (1994). *Affect regulation and the origin of the self: The neurobiology of emotional development*. Mahway, NJ: Erlbaum.

Schore, A. N. (2000). Attachment and the regulation of the right brain. *Attachment & Human Development, 2*(1), 23-47.

Schore, A. N. (2001). The effects of early relational trauma on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal, 22*(1-2), 201-269.

Schore, J. R., & Schore, A. N. (2008). Modern attachment theory: The central role of affect regulation in development and treatment. *Clin. Soc. Work J., 36*(1), 9-20.

Segal, Z., Williams, J. M. G., & Teasdale, J. D. (2002). *Mindfulness-based cognitive therapy for depression*. New York: The Guilford Press.

Segal, Z. V. (2002). *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse*. New York: New York : Guilford Press.

Şen, S., & Kavlak, O. (2012). Transgenerational attachment in Manisa, Turkey. *Contemporary Nurse: A Journal for the Australian Nursing Profession, 41*(1), 126-132.

Shapiro, S. L., Carlson, L. E., Astin, J. A., & Freedman, B. (2006). Mechanisms of mindfulness. [Article]. *Journal of Clinical Psychology, 62*(3), 373-386.

Shaver, P. R., & Mikulincer, M. (2004). What do self-report attachment measures assess? In W. S. Rholes & J. A. Simpson (Eds.), *Adult attachment: Theory, research, and clinical implications*. New York: The Guilford Press.

Sheeber, L. B., & Johnson, J. H. (1994). Evaluation of a temperament-focused, parent-training program. *Journal of Clinical Child Psychology, 23*(3), 249.

Shumow, L., & Lomax, R. (2002). Parental Efficacy: Predictor of Parenting Behavior and Adolescent Outcomes. [Article]. *Parenting: Science & Practice, 2*(2), 127.

Siegel, D. J. (1999). *The developing mind: Toward a neurobiology of interpersonal experience*. New York: Guilford Press.

Siegel, D. J., & Hartzell, M. (2003). *Parenting from the Inside Out: How a Deeper Self-Understanding Can Help You Raise Children Who Thrive.* New York: Penguin.

Siegel, R. D., Germer, C. K., & Olendzki, A. (2009). Mindulness: What is it? Where did it come from? In F. Didonna (Ed.), *Clinical handbook of mindfulness*. New York, NY: Springer.

Siegel, S. (1957). Nonparametric Statistics. *The American Statistician, 11*(3), 13-19.

Singh, N. N., Lancioni, G., Winton, A., Singh, J., Curtis, W., Wahler, R. G., & McAleavey, K. (2007). Mindful parenting decreases aggression and increases social behavior in children with developmental disabilities. *Behav. Modificat., 31*(6), 749-771.

Singh, N. N., Lancioni, G., Winton, A., Singh, J., Singh, A., Adkins, A. D., & Wahler, R. G. (2010). Training in Mindful Caregiving Transfers to Parent-Child Interactions. *J. Child Fam. Stud., 19*(2), 167-174.

Singh, N. N., Lancioni, G. E., Winton, A. S. W., Fisher, B. C., Wahler, R. G., McAleavey, K., . . . Sabaawi, M. (2006). Mindful Parenting Decreases Aggression, Noncompliance, and Self-Injury in Children With Autism. *Journal of Emotional and Behavioral Disorders, 14*(3), 169-177.

Singh, N. N., Singh, A. N., Lancioni, G. E., Singh, J., Winton, A. S. W., & Adkins, A. D. (2010). Mindfulness Training for Parents and Their Children With ADHD Increases the Children's Compliance. [Article]. *Journal of Child and Family Studies, 19*(2), 157-166.

Skodol, A. E., Rosnick, L., Kellman, D., Oldham, J. M., & Hyler, S. E. (1988). Validating structured DSM-III—R personality disorder assessments with longitudinal data.-700 M. *The American Journal of Psychiatry, 145*(10), 1297-1299.

Skowron, E. A., & Friedlander, M. L. (1998). The Differentiation of Self Inventory: Development and Initial Validation. *Journal of Counseling Psychology, 45*(3), 235-246.

Slade, A. (2005). Parental reflective functioning: An introduction. [Article]. *Attachment & Human Development, 7*(3), 269-281.

Slade, A. (2006). Reflective Parenting Programs: Theory and Development. [Article]. *Psychoanalytic Inquiry, 26*(4), 640-657.

Slade, A., Aber, J. L., Bresgi, I., Berger, B., & Kaplan, B. (2004). *The Parent Development Interview-Revised*. Unpublished protocol. City University of New York. New York.

Slade, A., Grienenberger, J., Bernbach, E., Levy, D., & Locker, A. (2005). Maternal reflective functioning, attachment, and the transmission gap: A preliminary study. *Attachment & Human Development, 7*(3), 283-298.

Smith, J. A., & Osborn, M. (2008). Interpretative Phenomenological Analysis. In J. A. Smith (Ed.), *Qualitative Psychology: A Practical Guide to Research Methods*. London: Sage.

Soloff, P. H., & Millward, J. W. (1983). Developmental histories of borderline patients. *Comprehensive Psychiatry, 24*(6), 574-588.

Spradlin, S. E. (2003). *Don't let your emotions run your life: How dialectical behavior therapy can put you in control*. Oakland, CA: New Harbinger Publications.

Srivastava, M., Gupta, A., Talukdar, U., Kalra, B. P., & Lahan, V. (2011). Effect of Parental Training in Managing the Behavioral Problems of Early Childhood. *The Indian Journal of Pediatrics, 78*(8), 973-978.

Sroufe, L. A. (1996). *Emotional development: The organization of emotional life in the early years*. New York: Cambridge University Press.

Sroufe, L. A. (2000). Early relationships and the development of children. [Article]. *Infant Mental Health Journal, 21*, 67-74.

Stepp, S. D., Epler, A. J., Jahng, S., & Trull, T. J. (2008). The effect of dialectical behavior therapy skills use on borderline personality disorder features. *Journal of Personality Disorders, 22*(6), 549-563.

Stepp, S. D., Whalen, D. J., Pilkonis, P. A., Hipwell, A. E., & Levine, M. D. (2012). Children of mothers with borderline personality disorder: Identifying parenting behaviors as potential targets for intervention. *Personality Disorders: Theory, Research, and Treatment, 3*(1), 76-91.

Stern, A. (1938). Psychoanalytic investigation and therapy in the borderline group of neuroses. *The Psychoanalytic Quarterly, 7*, 467-489.

Stevenson, J., & Meares, R. (1992). An outcome study of psychotherapy for patients with borderline personality disorder. *American Journal of Psychiatry, 149*(3), 358-362.

Stone, M. H. (1990). *The fate of borderline patients*. New York: Guilford Press.

Suchman, N. E., DeCoste, C., Castiglioni, N., McMahon, T. J., Rounsaville, B., & Mayes, L. (2010). The Mothers and Toddlers Program, an attachment-based parenting intervention for substance using women: Post-treatment results from a randomized clinical pilot. *Attachment & Human Development, 12*(5), 483-504.

Tangney, J. P. (1996). Conceptual and methodological issues in the assessment of shame and guilt. *Behavioral Research and Therapy, 34*(9), 741-754.

Tangney, J. P., & Dearing, R. L. (2002). *Shame and Guilt*. New York: The Guilford Press.

Tangney, J. P., Miller, R., Flicker, L., & Barlow, D. (1996). Are shame, guilt, and embarrassment distinct emotions? *Journal Of Personality And Social Psychology, 70*(6), 1256-1269.

Tangney, J. P., Wagner, P. E., & Gramzow, R. (1989). *The test of self-conscious affect*. Fairfax, VA: George Mason University.

Taylor, C. (2012). *Empathic Care for Children with Disorganized Attachments: A Model for Mentalizing, Attachment and Trauma-Informed Care*. London: Jessica Kingsley Publishers.

Teasdale, J. D., Moore, R. G., Hayhurst, H., Pope, M., Williams, S., & Segal, Z. V. (2002). Metacognitive awareness and prevention of relapse in depression: Empirical evidence. *Journal of Consulting and Clinical Psychology, 70*(2), 275-287.

Teasdale, J. D., Scott, J., Moore, R. G., Hayhurst, H., Pope, M., & Paykel, E. S. (2001). How does cognitive therapy prevent relapse in residual depression? Evidence from a controlled trial. *Journal of Consulting and Clinical Psychology, 69*(3), 347-357.

Tebartz van Elst, L., Hesslinger, B., Thiel, T., Geiger, E., Haegele, K., Lemieux, L., . . . Ebert, D. (2003). Frontolimbic brain abnormalities in patients with borderline personality disorder: a volumetric magnetic resonance imaging study. *Biological psychiatry, 54*(2), 163-171.

Teicher, M. H., Anderson, C. M., & Polcari, A. (2012). Childhood maltreatment is associated with reduced volume in the hippocampal subfields CA3, dentate gyrus, and subiculum. *Proceedings of the National Academy of Sciences of the United States of America, 109*(9), E563-572.

Teti, D. M., & Gelfand, D. M. (1991). Behavioral competence among mothers of infants in the first year: the mediational role of maternal self-efficacy. *Child development, 62*(5), 918-929.

Teti, D. M., Messinger, D., Gelfand, D. M., & Isabella, R. (1995). Maternal depression and the quality of early attachment: An examination of infants, preschoolers, and their mothers. *Developmental Psychology, 31*(3), 364-376.

Teyber, E., & McClure, F. H. (2011). *Interpersonal process in therapy: An integrative model* (6th ed.). Belmont, CA: Brooks/Cole.

Tomko, R. L., Trull, T. J., Wood, P. K., & Sher, K. J. (2014). Characteristics of borderline personality disorder in a community sample: Comorbidity, treatment utilization, and general functioning. *Journal of Personality Disorders, 28*(5), 734-750.

Torgensen, S. (2005). Genetics of borderline personality disorder. In M. Zanarini (Ed.), *Borderline Personality Disorder*. New York: Taylor and Francis.

Torgersen, S., & Alnæs, R. (1992). Differential perception of parental bonding in schizotypal and borderline personality disorder patients. *Comprehensive Psychiatry, 33*(1), 34-38.

Torgersen, S., Kringlen, E., & Cramer, V. (2001). The prevalence of personality disorders in a community sample. *Archives of general psychiatry, 58*(6), 590-596.

Torgersen, S., Lygren, S., Øien, P. A., Skre, I., Onstad, S., Edvardsen, J., . . . Kringlen, E. (2000). A twin study of personality disorders. *Comprehensive Psychiatry, 41*(6), 416-425.

Traskman-Bendz, L. I. L., Asberg, M., & Schalling, D. (1986). Serotonergic Function and Suicidal Behavior in Personality Disordersa. *Annals of the New York Academy of Sciences, 487*(1), 168-174.

Twohig, M. P. (2012). Acceptance and Commitment Therapy: Introduction. *Cognitive and Behavioral Practice, 19*(4), 499-507.

Umemura, T., Jacobvitz, D., Messina, S., & Hazen, N. (2013). Do toddlers prefer the primary caregiver or the parent with whom they feel more secure? The role of toddler emotion. *Infant Behavior and Development, 36*(1), 102-114.

van den Boom, D. C. (1994). The influence of temperament and mothering on attachment and exploration: an experimental manipulation of sensitive responsiveness among lower-class mothers with irritable infants. *Child Development, 65*(5), 1457-1477.

van den Boom, D. C. (1995). Do First-Year Intervention Effects Endure? Follow-up During Toddlerhood of a Sample of Dutch Irritable Infants. *Child Development, 66*(6), 1798-1816.

van der Oord, S., Bögels, S., & Peijnenburg, D. (2012). The Effectiveness of Mindfulness Training for Children with ADHD and Mindful Parenting for their Parents. *Journal of Child and Family Studies, 21*(1), 139-147.

Van IJzendoorn, M. (1995). Adult attachment representations, parental responsiveness, and infant attachment: a meta-analysis on the predictive validity of the Adult Attachment Interview. *Psychological bulletin, 117*(3), 387.

Van Ijzendoorn, M. H., Juffer, F., & Duyvesteyn, M. G. C. (1995). Breaking the intergenerational cycle of insecure attachment: A review of the effects of attachment-based interventions on maternal sensitivity and infant security.

Journal of Child Psychology and Psychiatry and Allied Disciplines, 36(2), 225-248.

van Ijzendoorn, M. H., Schuengel, C., & Bakermans-Kranenburg, M. J. (1999). Disorganized attachment in early childhood: Meta-analysis of precursors, concomitants, and sequelae. *Development and Psychopathology, 11*(02), 225-250.

Verheul, R., Van Den Bosch, L., Koeter, M., De Ridder, M., Stijnen, T., & Van Den Brink, W. (2003). Dialectical behaviour therapy for women with borderline personality disorder. *12-month, randomised clinical trial in The Netherlands, 182*(2), 135-140.

Vieten, C., & Astin, J. (2008). Effects of a mindfulness-based intervention during pregnancy on prenatal stress and mood: results of a pilot study. [Article]. *Archives of Women's Mental Health, 11*(1), 67-74.

Vieten, C., & Boorstein, S. (2009). *Mindful Motherhood : Practical Tools for Staying Sane During Pregnancy and Your Child's First Year*. Oakland: New Harbinger Publications.

Wallin, D. J. (2007). Attachment in psychotherapy. New York: Guilford Press.

Warner, J. (2006). *Perfect madness: Motherhood in the age of anxiety*. New York: Riverhead Books.

Warren, R. (2015). Emotion regulation in borderline personality disorder: The role of self-criticism, shame, and self-compassion. *Personality and Mental Health, 9*(1), 84-86.

Watson, C., Rao, S., & Beatson, J. (2010). Management of borderline personality disorder in public mental health settings. In J. Beatson, S. Rao & C. Watson

(Eds.), *Borderline Personality Disorder: Towards effective treatment* (pp. 269-292). Fitzroy, Australia: Australian Postgraduate Medicine.

Weaver, T. L., & Clum, G. A. (1993). Early family environments and traumatic experiences associated with borderline personality disorder. *Journal of Consulting and Clinical Psychology, 61*(6), 1068-1075.

Wei, M., Russell, D. W., Mallinckrodt, B., & Vogel, D. L. (2007). The Experiences in Close Relationship Scale (ECR)-short form: Reliability, validity, and factor structure. *Journal of Personality Assessment, 88*(2), 187-204.

Weijer-Bergsma, E., Formsma, A., Bruin, E., & Bögels, S. (2012). The Effectiveness of Mindfulness Training on Behavioral Problems and Attentional Functioning in Adolescents with ADHD. *Journal of Child and Family Studies, 21*(5), 775-787.

Weinfield, N. S., Sroufe, L. A., Egeland, B., & Carlson, E. (2008). Individual differences in infant-caregiver attachment: Conceptual and empirical aspects of security. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of Attachment, Second Edition: Theory, Research, and Clinical Applications* (2nd ed., pp. 78-101). New York: Guilford Publications.

Weiss, M., Zelkowitz, P., Feldman, R. B., Vogel, J., Heyman, M., & Paris, J. (1996). Psychopathology in offspring of mothers with borderline personality disorder: A pilot study. *The Canadian Journal of Psychiatry / La Revue canadienne de psychiatrie, 41*(5), 285-290.

Westbrook, L. F., & Jackson, M. H. (2009). *Borderline Personality Disorder: New Research*. New York: Nova Science Publishers, Inc.

Widiger, T. A. (2005). A temperament model of borderline personality disorder. In M. C. Zanarini (Ed.), *Borderline Personality Disorder* (pp. 63-82). New York: Informa Healthcare.

Wilberg, T., Dammen, T., & Friis, S. (2000). Comparing Personality Diagnostic Questionnaire-4+ with Longitudinal, Expert, All Data (LEAD) standard diagnoses in a sample with a high prevalence of axis I and axis II disorders. *Comprehensive Psychiatry, 41*(4), 295-302.

Winnicott, D. W. (1953). Transitional Objects and Transitional Phenomena: A Study of the First Not-Me Possession. *International Journal of Psycho-Analysis, 34*, 89-97.

Wnuk, S., McMain, S., Links, P. S., Habinski, L., Murray, J., & Guimond, T. (2013). Factors Related to Dropout From Treatment in Two Outpatient Treatments for Borderline Personality Disorder. *Journal of Personality Disorders, 27*(6), 716-726.

Wupperman, P., Fickling, M., Klemanski, D. H., Berking, M., & Whitman, J. B. (2013). Borderline Personality Features and Harmful Dysregulated Behavior: The Mediational Effect of Mindfulness. *Journal of Clinical Psychology, 69*(9), 903-911.

Wupperman, P., Neumann, C. S., & Axelrod, S. R. (2008). Do deficits in mindfulness underlie borderline personality features and core difficulties? *Journal of Personality Disorders, 22*(5), 466-482.

Wupperman, P., Neumann, C. S., Whitman, J., & Axelrod, Sr. (2009). The Role of Mindfulness in Borderline Personality Disorder Features. *J. Nerv. Ment. Dis., 197*(10), 766-771.

Yalom, I. D., & Leszcz, M. (2005). *The theory and practice of group psychotherapy* (5th ed.). New York: Basic Books.

Yalom, I. D., & Leszcz, M. (2005). The therapist: Transference and transparency *The theory and practice of group psychotherapy* (5th ed.). New York: Basic Books.

Yeomans, F. E., & Levy, K. N. (2002). An object relations perspective on borderline personality. *Acta Neuropsychiatrica, 14*(2), 76-80.

Zalewski, M., Stepp, S. D., Whalen, D. J., & Scott, L. N. (2015). A qualitative assessment of the parenting challenges and treatment needs of mothers with borderline personality disorder. *Journal of Psychotherapy Integration, 25*(2), 71-89.

Zanarini, M. (2000). Childhood experiences associated with the development of Borderline Personality Disorder. *Psychiatric Clinics of North America, 23*(1), 89-101.

Zanarini, M. C. (2005). *Borderline Personality Disorder*. New York: Taylor and Francis.

Zanarini, M. C., Frankenburg, F. R., Hennen, J., Reich, D. B., & Silk, K. R. (2004). Axis I comorbidity in patients with borderline personality disorder: 6-year follow-up and prediction of time to remission. *The American Journal of Psychiatry, 161*(11), 2108-2114.

Zanarini, M. C., Frankenburg, F. R., Hennen, J., Reich, D. B., & Silk, K. R. (2005). The McLean Study of Adult Development (MSAD): overview and implications of the first six years of prospective follow-up. *Journal of Personality Disorders, 19*(5), 505-523.

Zanarini, M. C., Frankenburg, F. R., Khera, G. S., & Bleichmar, J. (2001). Treatment histories of borderline inpatients. *Comprehensive Psychiatry, 42*(2), 144-150.

Zanarini, M. C., Frankenburg, F. R., Reich, D. B., & Fitzmaurice, G. (2012). Attainment and Stability of Sustained Symptomatic Remission and Recovery Among Patients With Borderline Personality Disorder and Axis II Comparison

Subjects: A 16-Year Prospective Follow-Up Study. *American Journal of Psychiatry, 169*(5), 476-483.

Zanarini, M. C., Frankenburg, F. R., Reich, D. B., Fitzmaurice, G., Weinberg, I., & Gunderson, J. G. (2008). The 10-year course of physically self-destructive acts reported by borderline patients and axis II comparison subjects. *Acta Psychiatr Scand, 117*, 117-184.

Zanarini, M. C., Frankenburg, F. R., Reich, D. B., & Marino, M. F. (2000). Biparental failure in the childhood experience of borderline patients. *Journal of Personality Disorders, 14*(3), 264-273.

Zanarini, M. C., Gunderson, J., Marino, M., Schwartz, E. O., & Frankenburg, F. (1989). Childhood experiences of borderline patients. *Compr. Psychiat., 30*(1), 18-25.

Zanarini, M. C., Williams, A., Lewis, R. E., Reich, B. R., Vera, S. C., Marino, M. F., . . . Frankenburg, F. R. (1997). Reported pathological childhood experiences associated with the development of borderline personality disorder. *The American Journal of Psychiatry, 154*(8), 1101-1106.

Zanarini, M. C., Yong, L., Frankenburg, F. R., Hennen, J., Reich, D. B., Marino, M. F., & Vujanovic, A. A. (2002). Severity of reported childhood sexual abuse and its relationship to borderline psychopathology and psychosocial impairment among borderline patients. *The Journal of Nervous and Mental Disease, 190*(6), 381-387.

Zweig-Frank, H., & Paris, J. (1991). Parents' Emotional Neglect and Overprotection According to the Recollections of Patients with Borderline Personality Disorder. *The American Journal of Psychiatry, 148*(5), 648-651.

Appendix A

MINDFULNESS PARENTING GROUP NORMS

Confidentiality:

- Personal information shared in the group is not talked about outside the group.

Treating each other with respect:

- Listening to each other and sharing the time.
- Phrasing feedback and suggestions as positive requests rather than criticism.
- Focusing on ourselves rather than trying to change other group members.
- Allowing for silence if others don't want to discuss something.
- Consideration of what might be distressing for others.
- Attending sober and not drug affected.
- Mobile phones switched off/silent mode.

Taking a break:

- Taking time-out for a short period if feeling distressed or overwhelmed.
- Letting a facilitator know you will return in a few minutes.
- Asking for support from a facilitator if needed.

Norms for attendance:

- Attending on time.
  If running late contact: 0439 960 965 or reception on 9214 8653
- Making a commitment to attending as many sessions as possible.

Other agreed or amended norms:

Appendix B

Overview of program content

Session 1: Mindfulness and parenting introduction.

- Introductions – facilitators and participants.
- Discussion - the mothers' motivations for participating in the group.
- Group norms – handout discussed with participants to give feedback and suggest additional norms.
- Psychoeducation - introduction to mindfulness and how it can be helpful to the individual.
- Discussion - participants' experiences with mindfulness. Facilitators share their own experiences of learning to use mindfulness, highlighting that it takes practice to develop mindfulness, and obstacles such as getting distracted by thoughts and judgements.
- Discussion - how mindfulness can help with parenting and emotion management.
- Mindfulness exercise – Present moment awareness of an object.
- Discussion - participants' experiences of the exercise, with facilitators highlighting that different people can find different mindfulness exercises helpful.
- A reminder that it takes time to develop mindfulness and to have realistic expectations when first practicing mindfulness.
- Discussion - possible obstacles to mindfulness practice and which times and places participants can practice (e.g. practicing mindfulness at a time when not too stressed or emotional).

Home practice:

- Encourage participants to practice present moment awareness of an object at least three times during the week.
- Facilitators highlight the utility of noting when home practice is not done and what the obstacles were so that we can learn from these.

Resources:

- Group norms handout.
- Introduction to mindfulness handout.

- 'What is mindfulness' handout from *Wise Choices: Acceptance and commitment therapy groups for people with borderline personality disorder* (Morton & Shaw, 2012).
- CD 1 with guided mindfulness tracks:
    - Present moment awareness of an object.
    - Mindful listening
    - Three minute mindful breathing space
    - Mindfulness of Sounds
    - Mindfulness of Taste
    - Leaves on a Stream
    - Loving Kindness Self-Compassion

Recommended reading:

- 'Riding the waves of motherhood' chapter from *Mindful motherhood: Practical tools for staying sane during pregnancy and you child's first year* (Vieten & Boorstein, 2009).

Session 2: More mindfulness and parenting.

- Mindfulness exercise – Present moment awareness of an object.
- Reflection on mindfulness home practice – experiences, what was noticed, what obstacles arose, how to overcome these obstacles.
- Review and reflection of the previous session.
- Discussion - difficult thoughts the participants have about themselves as mothers.
- Psychoeducation - using mindfulness to notice our thoughts and the judgements we automatically make about 'good' and 'bad', and that it can take time to notice these. Highlighting that mindfulness practice can help participants to become more aware of these thoughts and that mindfulness can be used to reduce automatic reactions to our thoughts.
- Mindfulness exercise – Mindful listening that includes directing attention to the sensations of breathing.
- Discussion - participants' experiences of the exercise.

Home practice:

- Mindful listening at least three times during the week.

- Take time during the week to pay attention to something mindfully at least three times, can be the same type of thing or different things (e.g. eating, washing dishes, having a shower, mindful walking).
- Discussion of ideas for home practice and potential obstacles.

Resources:

- Day to day informal mindfulness handout.
- Mindfully focus on just one thing handout from *Wise Choices: Acceptance and commitment therapy groups for people with borderline personality disorder* (Morton & Shaw, 2012).

Recommended reading:

- 'Three elements of experience' chapter from *Mindful motherhood: Practical tools for staying sane during pregnancy and you child's first year* (Vieten & Boorstein, 2009).

Session 3: Mindfulness to increase awareness.

- Mindfulness exercise – Mindful listening.
- Reflection on mindfulness home practice.
- Review and reflection of the previous session.
- Handouts - lists of body sensations, emotions and potential related thoughts.
- Discussion - how during mindfulness one might notice body sensations, thoughts, emotions and that these also might not be noticed and that this is not right or wrong, as mindfulness is about noticing and observing one's own personal experience.
- Awareness of internal reactions exercise:
    - Video of a beach with foreboding 'Jaws' music playing and then with relaxation music playing.
    - Participants to write the body sensations, thoughts, and emotions experienced on a CBT monitoring sheet.
    - Discussion - what participants noticed and the different responses to different music, of how it is what is in our minds rather than the actual external reality that often colours our thoughts, feelings and reactions to situations.

- Psychoeducation - using mindfulness to increase awareness of experience, and for grounding to reduce distress about emotions being experienced.
- Discussion - the mind's tendency to make judgements, the judgements we make in response to our experiences, and the negative impacts of this.
- Psychoeducation - how mindfulness can be used to increase acceptance of thoughts and reduce judgemental self-evaluations.
- Mindfulness exercise – Three minute mindful breathing space.
- Discussion - participants' experiences of the exercise.

Home practice:

- Three minute mindful breathing space at least three times during the week.
- Take time during the week to pay attention to something mindfully at least three times, can be the same type of thing or different things (e.g. eating, washing dishes, having a shower, mindful walking).

Resources:

- Handouts - lists of body sensations, emotions and potential related thoughts.
- CBT monitoring sheets.
- 'Different ways to relate to thoughts' and 'Watching your thoughts' handouts from *Wise Choices: Acceptance and commitment therapy groups for people with borderline personality disorder* (Morton & Shaw, 2012).

Recommended reading:

- 'The balloon in the breadbox' and 'Ocean of mindful awareness' chapters from *Mindful motherhood: Practical tools for staying sane during pregnancy and you child's first year* (Vieten & Boorstein, 2009).

Session 4: Mindfulness and acceptance.

- Mindfulness exercise – Three minute mindful breathing space.
- Reflection on mindfulness home practice.
- Review and reflection of the previous session.
- Discussion - thoughts, judgements, and responses to these that participants have noticed; particularly about the self as a person and as a mother.
- Further psychoeducation and discussion about mindfulness and acceptance, highlighting what acceptance is and is not.

- Psychoeducation - how a mindful approach to parenting can change the experience of, and relationship with your child.
- Awareness of internal reactions exercise 2:
    - YouTube video of a child throwing a tantrum and then of a child happily playing.
    - Participants - to notice any body sensations, thoughts, and emotions experienced.
    - Discussion about each child's behaviours and what they might be communicating with the behaviours.
    - Discussion - participants' experiences while watching the videos, the differences in experience for each video, and why we have these responses.
- Discussion - using mindfulness to increase our awareness of these experiences and to choose a response rather than reacting automatically.
- Mindfulness exercise – Mindfulness of sounds.
- Discussion - participants' experiences of the exercise.

Home practice:

- Noticing internal reactions to your child (physical sensations, thoughts, and emotions).
- Try the 'It is as it is' exercise from *Mindful motherhood: Practical tools for staying sane during pregnancy and you child's first year* (Vieten & Boorstein, 2009) when faced with at least one stressful situation.
- Practice mindfulness of sounds at least once during the week.

Resources:

- 'Pain is inevitable; suffering is optional' handout from *Wise Choices: Acceptance and commitment therapy groups for people with borderline personality disorder* (Morton & Shaw, 2012).

Recommended reading:

- 'Acceptance: Meeting motherhood as it is' and 'Nonstriving' chapters from *Mindful motherhood: Practical tools for staying sane during pregnancy and you child's first year* (Vieten & Boorstein, 2009).

Session 5: Attachment security.

- Mindfulness exercise – Mindfulness of sounds.
- Reflection on mindfulness home practice.
- Review and reflection of the previous session.
- Psychoeducation - attachment security with a focus on the needs of children and the role of the parent.
- YouTube video demonstrating the Circle of Security (COS) attachment model.
- Discussion - the COS model with a focus on the relationship between the mothers and their children, and their experiences in childhood with their own parents.
- Discussion - times when participants' involvement with their children is overdone or underdone.
    - Participants to reflect on when this may have occurred in their own childhood experiences.
    - Explore possibilities for a middle ground with their children.
- Facilitators emphasise and discuss having a non-judgemental and compassionate stance towards themselves and their children.
- Discussion - using mindfulness to improve parenting skills for encouraging secure attachment.
- Discussion - potential obstacles and how to overcome these.
- Self-compassion exercise – Loving kindness self-compassion.
- Discussion - participants' experiences of the exercise.
- Discussion - potential obstacles to noticing children's attachment behaviours and how to overcome these.

Home practice:

- Paying attention to the attachment behaviours described in the COS model with your own child at least three times during the week.
- Noticing your own response, and times you overdo or underdo involvement or comfort.
- Loving Kindness Self-Compassion exercise.

Resources:

- COS Handouts:
    - ‘COS 25 Words or less’
    - ‘COS Original Circle’
    - ‘COS in a Chaotic World’
    - ‘COS Circle of Repair’
    - ‘COS Note to Parents’
    - ‘Travelling Around COS’
    - ‘COS Time In’

Session 6: Mindfulness for difficult thoughts.

- Self-compassion exercise – Loving kindness self-compassion.
- Reflection on mindfulness and self-compassion home practice.
- Review and reflection of the previous session.
- Discussion - the reality of motherhood compared to how it can be portrayed.
- Discussion - difficult/scary thoughts mothers have, with a focus on normalising.
- Psychoeducation - thoughts just being thoughts rather than facts.
- Discussion - using mindfulness to notice and stay present with difficult thoughts and feelings.
- Discussion - complimentary and additional strategies for managing difficult thoughts: Non-judgement, acceptance, self-compassion, self-nurturing, seeking support, and distraction.
- Mindfulness exercise – Leaves on a stream.
- Discussion - participants’ experiences of the exercise and what they noticed about their thoughts during it.

Home practice:

- Leaves on a stream at least three times during the week.

Resources:

- List of difficult/scary thoughts mothers can have handout.

Recommended reading:

- ‘The great storyteller’, ‘True blues’, ‘Troubleshooting defusion’, ‘Look who’s talking’, and ‘Scary pictures’ chapters from *The Happiness Trap (Harris, 2007).*

Session 7: Self-evaluations and self-compassion.

- Mindfulness exercise – Leaves on a stream.
- Reflection on mindfulness home practice.
- Review and reflection of the previous session.
- Discussion - thoughts not being facts, the evaluating mind, and different types of evaluations.
- Discussion - how mindfulness can be used to increase our objectivity.
- Discussion - the importance of self-compassion and nurturing the self.
- Discussion - self-care and pleasurable activities.
- Self-compassion exercise – Soften soothe allow.
- Discussion - participants' experiences of the exercise and what they noticed about their thoughts during it.

Home practice:

- Mindfulness of pleasure at least three times during the week.
    - Experimenting with objects or activities that might bring pleasure.
- Soften soothe allow exercise.

Resources:

- CD 2:
    - Thank you mind
    - Labelling thoughts and feelings
    - Mindfulness of emotions
    - Noticing self-critical commentary

Recommended reading:

- 'Cradling your experience' and 'Embodied mindful motherhood' chapters from *Mindful motherhood: Practical tools for staying sane during pregnancy and you child's first year* (Vieten & Boorstein, 2009).

Session 8: Mindfulness of emotions.

- Mindfulness exercise – Thank you mind
- Reflection on mindfulness and self-compassion home practice.
- Review and reflection of the previous session.

- Discussion – identifying emotions, and difficult thoughts that may come up as participants explore emotion awareness.
- Discussion - the functions of emotions.
- Discussion - the temporary nature of emotions.
- Handout - Identifying emotions and crisis survival skills.
- Introduction to distress tolerance (crisis survival and acceptance) and a discussion about crisis survival strategies for participants to use in developing their 'responding to emotions plan'.
- Mindfulness exercise – Labelling thoughts and feelings.
- Discussion - participants' experiences of the exercise and what they noticed about their thoughts and emotions during it.
- Facilitators to highlight potential difficulties that may arise for participants around the emotion focused sessions and for participants to notice that they might want to avoid attending those sessions. Participants are encouraged to contact facilitators if this occurs.

Home practice:

- Practice noticing and labelling emotions.
- Practice self-compassion to help with emotion management.
- Practice mindfulness of thoughts and emotions using guided mindfulness tracks from CD 2 or 3 as appropriate for the individual (depending on level of capacity and tolerance).

Resources:

- Crisis survival skills reading from *Don't let emotions run your life: How dialectical behaviour therapy can put you in control* (Spradlin, 2003).
- Emotions chart
- Emotions thesaurus adapted from (Spradlin, 2003).
- Responding to emotions plan
- CD 3:
    - Body scan
    - Mindfulness of the body

Session 9: Mindfulness for managing emotions.

- Mindfulness exercise – Labelling thoughts and feelings.
- Reflection on mindfulness and self-compassion home practice.
- Review and reflection of the previous session.
- Review participants' 'responding to emotions plan', highlighting the importance of developing this plan for times of intense emotions.
- Highlighting the importance of self-compassion when trying to deal with difficult emotions.
- Highlight next session's content – different ways of relating to emotions with a focus on emotion acceptance for emotion management.
- Discussion - the messages given about emotions in our family of origin, the connection to our current relationship with emotions, and how emotions are managed.
    - Highlight potential distress this reflection can raise.
- Mindfulness self-compassion exercise – Mindfulness of emotion in the body.
- Discussion - participants' experiences of the exercise.

Home practice:

- Practice paying attention to emotions mindfully (starting with mild emotions).
    - Notice whether the emotions are like a wave.
- Family of origin emotions worksheet for discussion next session.
- Practice self-compassion to help with emotion management.

Resources:

- 'How emotions can help us live a full, rich, and meaningful life' and 'Emotions pass like a wave' handouts from *Wise Choices: Acceptance and commitment therapy groups for people with borderline personality disorder* (Morton & Shaw, 2012).
- Family of origin emotions worksheet.

Session 10: Emotion acceptance.

- Mindfulness exercise – Three minute mindful breathing space.
- Reflection on mindfulness and self-compassion home practice.
- Review and reflection of the previous session with a focus on any distress or difficulties raised by family of origin reflection.
- Discussion - family of origin emotions exercise.
- Psychoeducation and discussion - fighting and avoiding emotions.
- Psychoeducation - mindfulness and acceptance for emotion management.
- Psychoeducation and discussion - developing acceptance.
- Mindfulness exercise - Mindfulness of emotions.
- Discussion - participants' experiences of the exercise.

Home practice:

- Continue mindfulness practice with participants' own choice of emotion mindfulness/self-compassion tracks, relate to level of emotion tolerance.
- Complete types of mother worksheets (ideal mother, the mother I don't want to be, good enough mother) for discussion next session.
- Highlight that if participants are distressed or have a lot of difficulty with any of these to just try their best and bring the worksheets to the session for discussion.

Resources:

- 'Mindfulness and acceptance strategies for emotions, sensations and urges' handout from *Wise Choices: Acceptance and commitment therapy groups for people with borderline personality disorder* (Morton & Shaw, 2012).

Session 11: The good enough mother.

- Mindfulness exercise – Mindfulness of emotions.
- Discussion - participants' experiences of the exercise.
- Reflection on mindfulness and self-compassion home practice.
- Review and reflection of the previous session.
- Discussion - what participants noticed about what their 'ideal mother', 'mother I don't want to be', and 'good enough mother'.
- Discussion - being a good enough mother.

- Discussion - perceptions we have of our children compared to how children actually are, and about the issues we have with our children and what buttons they push.
- Psychoeducation - the 'good enough child'.
- View Watch, Wait and Wonder approach to parenting YouTube video.
    - Discussion – what participants think about this approach and how it relates with the COS model.
- Discussion - the upcoming group ending, participants' feelings about this, and where to now.
- Mindfulness exercise - Expanding your container (focusing on an uncomfortable body sensation, thought or emotion).
- Discussion - participants' experiences of the exercise.

Home practice:

- Continue mindfulness practice with participants' own choice of emotion mindfulness tracks.
- How do I want to parent worksheet for discussion next session.

Recommended reading:

- 'Connection: It isn't always easy', 'When the going gets rough', and 'Mindful decision making' chapters from *Mindful motherhood: Practical tools for staying sane during pregnancy and you child's first year* (Vieten & Boorstein, 2009).

Session 12: Mindful parenting.

- Mindfulness exercise - Expanding your container (focusing on an uncomfortable body sensation, thought or emotion).
- Discussion - participants' experiences of the exercise.
- Reflection on mindfulness home practice.
- Discussion – participants' 'how do I want to parent' worksheets.
    - Link to the good enough mother.
    - Link to values.
    - Ask participants if there are times they are parenting in the way they want.
    - Discuss obstacles and how to overcome these.

- Discussion - how we can use mindfulness to enact our parenting values and be the parent we want to be.
- Reflection on the purpose of the work done in the program, with a focus on relationships with their children and with others.
- Review and reflection of the program.
    - With individual feedback given to participants by facilitators.
- Celebration for completing the program
    - Certificates of completion given to participants.

Resources:

- Overview of program sessions handout.
- Suggested reading list provided.

Recommended reading:

- 'The dance of mindful motherhood' and 'The bad, the ugly, and don't forget the good' chapters from *Mindful motherhood: Practical tools for staying sane during pregnancy and you child's first year* (Vieten & Boorstein, 2009).

Appendix C

SWINBURNE UNIVERSITY OF TECHNOLOGY

MINDFULNESS PARENTING GROUP PROGRAM FOR MOTHERS WITH BORDERLINE PERSONALITY DISORDER

A mindfulness-based parenting program has been developed by Natasha Rogers, as part of her clinical psychology doctorate, with Dr Roslyn Galligan, a child and family clinical psychologist at Swinburne University. We will be facilitating the program together. This program is being piloted in a group setting for mothers who have a diagnosis of Borderline Personality Disorder and would like to improve their experience of being a mother and have a better relationship with their child.

We would be grateful if you could advertise this program to any clients who you think might be interested. We have attached a flyer to advertise the group to clients. Please contact us if you would like further information about this program.

Who:
We are looking for women who are interested in participating in a pilot study of this group program and meet the following criteria:

- Are over the age of 18.
- Have a child (or children) aged between 1 and 5 years.
- Have a current diagnosis of Borderline Personality Disorder.
- Are not identified as at high risk or in crisis.

The program involves developing mindfulness skills of awareness, acceptance, non-judgement and non-reactivity to help mothers to reduce stress and develop more satisfying relationships and ways of parenting. The program includes parenting and attachment education.

Potential Benefits:

- Stress reduction
- Decreased reactivity
- Increased acceptance of self and others
- Enhanced parenting skills
- An improved relationship with their child
- Strategies for dealing with difficult thoughts and emotions
- Developing relationships with other mothers

The evaluation component will involve an individual assessment interview and the completion of a number of questionnaires before the program begins, after the program ends, and 3 months after the program is completed.

Cost: Free

Dates/Time: Fridays at 10:30am – 12:30pm
Weekly sessions for 12 weeks from May 2013

Location: Swinburne University Psychology Clinic, Hawthorn

If you have any enquiries please contact:

Ms Natasha Rogers
0439 960 965
nrogers@swin.edu.au

Dr Roslyn Galligan
9214 5345
rgalligan@swin.edu.au

Appendix D

SWINBURNE UNIVERSITY OF TECHNOLOGY

MINDFULNESS PARENTING GROUP PROGRAM FOR MOTHERS WITH BORDERLINE PERSONALITY DISORDER

We would like to invite you to participate in a mindfulness-based parenting program at Swinburne University. This program will be conducted in a group setting of 10 participants. The group is being piloted for mothers who have a diagnosis of Borderline Personality Disorder who would like to improve their experience of being a mother and have a better relationship with their child.

This program is developed and facilitated by Natasha Rogers a provisional clinical psychologist, and Dr Roslyn Galligan a child and family clinical psychologist.

We are looking for women who:

- Are over the age of 18
- Have a diagnosis of Borderline Personality Disorder
- Have a young child (or children) aged between 1 and 5 years
- Are interested in participating in a pilot study of this program

The program involves developing mindfulness skills of awareness, acceptance, non-judgement, and non-reactivity to help mothers to reduce stress and develop more satisfying relationships and ways of parenting.

Potential benefits of the program are:

- Stress reduction
- Being less reactive
- Being more accepting of self and others
- Enhanced parenting skills
- An improved relationship with your child
- Strategies for dealing with difficult thoughts and emotions
- Developing relationships with other mothers

The evaluation component will involve an individual assessment interview and the completion of a number of questionnaires before the program begins, after the program ends, and 3 months after the program is completed.

Cost: Free

Dates/Time: Fridays at 10:30am – 12:30pm
Weekly sessions for 12 weeks from May 2013

Location: Swinburne University Psychology Clinic, Hawthorn

If you are interested in participating in this program or have any enquiries please contact:

Ms Natasha Rogers
0439 960 965
nrogers@swin.edu.au

Dr Roslyn Galligan
9214 5345
rgalligan@swin.edu.au

Appendix E

MINDFULNESS PARENTING PROGRAM FOR MOTHERS
PARTICIPANT INFORMATION FORM

Name:

Date of Birth:

Address:

Phone number/s:

Email address:

Marital/relationship status:

Number and age of children:

Who do you live with?

Does anyone else look after or babysit your child(ren)?

Education and work history:

Are you currently employed?

What kind of work do you do?

If not currently employed, when were you last employed?

What kind of work did you do?

How are you supporting yourself?

Are you currently receiving any psychological or psychiatric treatment or support?
Please describe:

Have you received any psychological or psychiatric treatment or support in the past?
Please describe including dates and timeframes if possible:

Have you had any diagnoses for mental health issues?
Please list including dates if possible:

Current mental health professionals or support workers name and contact details:

Name of next of kin (in case of emergency):

Contact number/s:

SWINBURNE UNIVERSITY OF TECHNOLOGY

Appendix F

INFORMATION STATEMENT

Mindfulness-Based Parenting Program for Mothers experiencing difficulties with Relationships, Emotions and Mood Variability

Investigators: Ms Natasha Rogers (Student Researcher) and Dr Roslyn Galligan (Supervisor)

The program

The parenting program is a cost-free mindfulness-based program for mothers experiencing some of the following difficulties:

- Reactive mood swings
- Intense and unstable relationships
- A changeable sense of self
- Intense anger or difficulty controlling anger
- Impulsivity
- Feelings of emptiness
- Self-harming behaviours

The program consists of twelve sessions, for two hours per week. It includes the development of mindfulness skills, nurturing of the self, reflective techniques, and parenting skills to improve the experience of being a mother and to develop more satisfying relationships and ways of parenting. Each session will include a break for refreshments and a chance to get to know each other.

We are offering the program to women over the age of 18 who have a young child (or children), are experiencing difficulties, and are interested in participating in a small pilot of this group program.

Potential benefits of this program are:

- Stress reduction
- Decreased reactivity
- Increased acceptance of self and others
- Enhanced parenting skills
- An improved relationship with your child
- Strategies for dealing with difficult thoughts and emotions
- Developing relationships with other mothers

As this is a pilot program, we wish to evaluate the effectiveness of the program. The investigators are interested in exploring the potential benefits of a mindfulness approach to parenting for mothers and to expand upon the available treatment programs. The study is being undertaken as a partial requirement for a postgraduate doctoral qualification in clinical psychology at Swinburne University.

We need a strong commitment from participants to attend all 12 sessions and complete the following:

- Interview: Before the program (approximately 45 minutes – 1 ½ hours).
- Questionnaire package: Before the program, after the program, and 3 months follow-up (approximately 1 hour each time).
- Post-session feedback form: Each week to obtain your feedback on the session (approximately 5 minutes).
- Focus group: After the program (approximately 1 hour).

Program Dates
The program runs for twelve weeks, for two hours per week on a Friday at 10:30am to 12:30pm. The program will run from June 2013 to August/September 2013.

Program Venue
Swinburne Psychology Clinic
Level 4, George Swinburne Building
34 Wakefield Street
Swinburne University, Hawthorn

Your consent is required for participation in the study, and is obtained by providing a signed consent form to the investigators prior to the initial interview.

Voluntary participation
Your participation in this program and all aspects of its evaluation are completely voluntary. If you agree to participate you may withdraw participation from the whole program or any of its components at any time by speaking to the facilitators.

Given that we aim to perform a sound evaluation of the program, we do ask that you carefully consider whether you are able to commit to attending the sessions and whether you are able to spend the time necessary to participate in the interviews and fill in questionnaires, as we do need a strong commitment from all participants in order to successfully evaluate the program.

Risks
The program explores emotional and psychological states, as well as encouraging reflection on participants' own family of origin. If any uncomfortable distress arises, the facilitators are available during and outside of the sessions to provide support and individual follow-up. Referrals will be provided to individual therapy as required.

Confidentiality – protecting your privacy and anonymity
Your privacy and confidentiality will be protected. Your responses to all questionnaires, interviews and within the program will be kept confidential. Cover sheets on questionnaires will be coded to protect your identity. All interviews will be audio-recorded and when interviews are transcribed, your name will not be used. Materials produced in sessions will be coded to protect your identity. Only the investigators will have access to your questionnaires, interviews, and the material produced in sessions, and the investigators will be responsible for data collection and secure storage. Consent forms will be stored securely and separately from the data, which only the investigators will have access to. You will be contacted approximately 3 months after the study by investigators to be asked to participate in a follow-up interview and to complete the questionnaire package.

Study results and ethical standards
The results of this research may be published in a scientific journal or presented at a professional conference. Results will be reported in a way that will not allow any individual to be identified. Quotes will be used to reflect themes from the interviews and materials produced in sessions will be used to reflect themes that emerged in the program, however no individual will be identifiable. This research conforms to the principles set out in the Swinburne University of Technology Policy on Research Ethics and the Australian National Health and Medical Research Council guidelines as specified in the National Statement on Ethical Conduct on Research Involving Humans.

Further information
If you have any questions about this study, please contact the research investigators:

- Natasha Rogers (Student Investigator)
  0439 960 965
  nrogers@swin.edu.au

- Dr Roslyn Galligan (Supervisor and Senior Investigator)
  (03) 9214 5345
  rgalligan@swin.edu.au

Concerns/complaints
This project has been approved by or on behalf of Swinburne's Human Research Ethics Committee (SUHREC) in line with the *National Statement on Ethical Conduct in Human Research*. If you have any concerns or complaints about the conduct of this project, you can contact:

Research Ethics Officer, Swinburne Research (H68),
Swinburne University of Technology, P O Box 218, HAWTHORN VIC 3122.
Tel (03) 9214 5218 or +61 3 9214 5218 or resethics@swin.edu.au

SWINBURNE UNIVERSITY OF TECHNOLOGY

CONSENT FORM

Project Title: Mindfulness-Based Parenting Program for Mothers experiencing difficulties with Relationships, Emotions and Mood Variability

Principal Investigator(s): Ms Natasha Rogers and Dr Roslyn Galligan

1. I consent to participate in the project named above. I have been provided a copy of the project consent information statement to which this consent form relates and any questions I have asked have been answered to my satisfaction.

2. ***In relation to this project, please circle your response to the following:***

▪ I agree to participate in the 12 program sessions	**Yes**	**No**
▪ I agree to be interviewed by the researchers	**Yes**	**No**
▪ I agree to allow the interviews to be recorded by electronic device	**Yes**	**No**
▪ I agree to complete the questionnaires	**Yes**	**No**
▪ I agree to allow materials produced to be available to the researchers	**Yes**	**No**
▪ I agree to make myself available for further information if required	**Yes**	**No**

3. I acknowledge that:
   (a) my participation is voluntary and that I am free to withdraw from the project at any time without explanation;
   (b) the Swinburne University project is for the purpose of research and not for profit;
   (c) any identifiable information about me which is gathered in the course of and as the result of my participating in this project will be (i) collected and retained for the purpose of this project and (ii) accessed and analysed by the researcher(s) for the purpose of conducting this project;
   (d) my anonymity is preserved and I will not be identified in publications or otherwise without my express written consent.

By signing this document I agree to participate in this project.

Name of Participant: ……

Signature & Date: ……

SWINBURNE UNIVERSITY OF TECHNOLOGY

Appendix G

CONSENT TO RELEASE INFORMATION

I give consent for information regarding my current and previous therapeutic treatment and/or support work or to be released to the principal investigators (Natasha Rogers and Dr Roslyn Galligan) for the purpose of the Swinburne University project 'Mindfulness-Based Parenting Program for Mothers experiencing difficulties with Relationships, Emotions and Mood Variability' by:

……
Name of health professional

from

……

……

……
Name and address of service/organisation

By signing this form I give consent for the information described above to be released:

Name:
……

Signature & Date:
……

SWINBURNE UNIVERSITY OF TECHNOLOGY

Appendix H

INFORMATION STATEMENT

Mindfulness-Based Parenting Program for Mothers experiencing difficulties with Relationships, Emotions and Mood Variability

Investigators: Ms Natasha Rogers (Student Researcher) and Dr Roslyn Galligan (Supervisor)

The program

The parenting program is a cost-free mindfulness-based program for mothers experiencing some of the following difficulties:

- Reactive mood swings
- Intense and unstable relationships
- A changeable sense of self
- Intense anger or difficulty controlling anger
- Impulsivity
- Feelings of emptiness
- Self-harming behaviours

The program consists of twelve sessions, for two hours per week. It includes the development of mindfulness skills, nurturing of the self, reflective techniques, and parenting skills to improve the experience of being a mother and to develop more satisfying relationships and ways of parenting. Each session will include a break for refreshments and a chance to get to know each other.

We are offering the program to women over the age of 18 who have a young child (or children), are experiencing difficulties, and are interested in participating in a small pilot of this group program.

Potential benefits of this program are:

- Stress reduction
- Decreased reactivity
- Increased acceptance of self and others
- Enhanced parenting skills
- An improved relationship with your child
- Strategies for dealing with difficult thoughts and emotions
- Developing relationships with other mothers

As this is a pilot program, we wish to evaluate the effectiveness of the program. The investigators are interested in exploring the potential benefits of a mindfulness approach to parenting for mothers and to expand upon the available treatment programs. The study is being undertaken as a partial requirement for a postgraduate doctoral qualification in clinical psychology at Swinburne University.

We need a strong commitment from participants to attend all 12 sessions and complete the following:

- Interview: Before the program (approximately 45 minutes – 1 ½ hours).
- Questionnaire package: Before the program, after the program, and 3 months follow-up (approximately 1 hour each time).
- Post-session feedback form: Each week to obtain your feedback on the session (approximately 5 minutes).
- Focus group: After the program (approximately 1 hour).

Program Dates
The program runs for twelve weeks, for two hours per week on a Friday at 12:30pm to 2:30pm. The program will run from March 2014 to June 2014.

Program Venue
Banyule Community Health
21 Alamein Road
Heidelberg West

Your consent is required for participation in the study, and is obtained by providing a signed consent form to the investigators prior to the initial interview.

Voluntary participation
Your participation in this program and all aspects of its evaluation are completely voluntary. If you agree to participate you may withdraw participation from the whole program or any of its components at any time by speaking to the facilitators.

Given that we aim to perform a sound evaluation of the program, we do ask that you carefully consider whether you are able to commit to attending the sessions and whether you are able to spend the time necessary to participate in the interviews and fill in questionnaires, as we do need a strong commitment from all participants in order to successfully evaluate the program.

Risks
The program explores emotional and psychological states, as well as encouraging reflection on participants' own family of origin. If any uncomfortable distress arises, the facilitators are available during and outside of the sessions to provide support and individual follow-up. Referrals will be provided to individual therapy as required.

Confidentiality – protecting your privacy and anonymity
Your privacy and confidentiality will be protected. Your responses to all questionnaires, interviews and within the program will be kept confidential. Cover sheets on questionnaires will be coded to protect your identity. All interviews will be audio-recorded and when interviews are transcribed, your name will not be used. Materials produced in sessions will be coded to protect your identity. Only the investigators will have access to your questionnaires, interviews, and the material produced in sessions, and the investigators will be responsible for data collection and secure storage. Consent forms will be stored securely and separately from the data, which only the investigators will have access to. You will be contacted approximately 3 months after the study by investigators to be asked to participate in a follow-up interview and to complete the questionnaire package.

Study results and ethical standards
The results of this research may be published in a scientific journal or presented at a professional conference. Results will be reported in a way that will not allow any individual to be identified. Quotes will be used to reflect themes from the interviews and materials produced in sessions will be used to reflect themes that emerged in the program, however no individual will be identifiable. This research conforms to the principles set out in the Swinburne University of Technology Policy on Research Ethics and the Australian National Health and Medical Research Council guidelines as specified in the National Statement on Ethical Conduct on Research Involving Humans.

Further information
If you have any questions about this study, please contact the research investigators:

- Natasha Rogers (Student Investigator)
  0439 960 965
  nrogers@swin.edu.au

- Dr Roslyn Galligan (Supervisor and Senior Investigator)
  (03) 9214 5345
  rgalligan@swin.edu.au

Concerns/complaints
This project has been approved by or on behalf of Swinburne's Human Research Ethics Committee (SUHREC) in line with the *National Statement on Ethical Conduct in Human Research*. If you have any concerns or complaints about the conduct of this project, you can contact:

Research Ethics Officer, Swinburne Research (H68),
Swinburne University of Technology, P O Box 218, HAWTHORN VIC 3122.
Tel (03) 9214 5218 or +61 3 9214 5218 or resethics@swin.edu.au

SWINBURNE UNIVERSITY OF TECHNOLOGY

CONSENT FORM

Project Title: Mindfulness-Based Parenting Program for Mothers experiencing difficulties with Relationships, Emotions and Mood Variability

Principal Investigator(s): Ms Natasha Rogers and Dr Roslyn Galligan

1. I consent to participate in the project named above. I have been provided a copy of the project consent information statement to which this consent form relates and any questions I have asked have been answered to my satisfaction.

2. ***In relation to this project, please circle your response to the following:***

▪ I agree to participate in the 12 program sessions	**Yes**	**No**
▪ I agree to be interviewed by the researchers	**Yes**	**No**
▪ I agree to allow the interviews to be recorded by electronic device	**Yes**	**No**
▪ I agree to complete the questionnaires	**Yes**	**No**
▪ I agree to allow materials produced to be available to the researchers	**Yes**	**No**
▪ I agree to make myself available for further information if required	**Yes**	**No**

3. I acknowledge that:
   (a) my participation is voluntary and that I am free to withdraw from the project at any time without explanation;
   (b) the Swinburne University project is for the purpose of research and not for profit;
   (c) any identifiable information about me which is gathered in the course of and as the result of my participating in this project will be (i) collected and retained for the purpose of this project and (ii) accessed and analysed by the researcher(s) for the purpose of conducting this project;
   (d) my anonymity is preserved and I will not be identified in publications or otherwise without my express written consent.

By signing this document I agree to participate in this project.

Name of Participant: ……

Signature & Date: ……

Appendix I

PDQ-4+

Please read the following statements and circle the response that best applies to you:

0 Never
1 Rarely
2 Sometimes
3 Often
4 Nearly always

1. I will go to extremes to prevent those I love from leaving me.	0	1	2	3	4
2. I either love someone or hate them with with nothing in between.	0	1	2	3	4
3. I often wonder who I really am.	0	1	2	3	4
4. I have tried to hurt or kill myself.	0	1	2	3	4
5. I am a very moody person.	0	1	2	3	4
6. I feel that life is dull or meaningless.	0	1	2	3	4
7. I have difficulty in controlling my anger or temper.	0	1	2	3	4
8. When I get stressed, things happen like I get paranoid or just black-out.	0	1	2	3	4
9. I am often impulsive and reckless in more than one area of my life.	0	1	2	3	4

Appendix J

BEST

Circle the number which indicates how much the item in each row has caused distress, relationships problems or difficulty with getting things done in the last 30 days.

Please read the following statements and circle the response that best applies to you:

1 None/Slight
2 Mild
3 Moderate
4 Severe
5 Extreme

1. Worrying that someone important in your life is tired of you or is planning to leave you.	1	2	3	4	5
2. Major shifts in your opinions about others such as switching from believing someone is a loyal friend or partner to believing the person is untrustworthy and hurtful.	1	2	3	4	5
3. Extreme changes in how you see yourself. Switching from feeling confident about who you are to feeling like you are evil, or that you don't even exist.	1	2	3	4	5
4. Severe mood swings several times a day. Minor events cause major shifts in mood.	1	2	3	4	5
5. Feeling paranoid or like you are losing touch with reality.	1	2	3	4	5
6. Feeling angry.	1	2	3	4	5
7. Feelings of emptiness.	1	2	3	4	5
8. Feeling suicidal.	1	2	3	4	5
9. Going to extremes to try to keep someone from leaving you.	1	2	3	4	5
10. Purposely doing something to injure yourself or making a suicide attempt.	1	2	3	4	5
11. Problems with impulsive behaviour (<u>not</u> counting suicide attempts or injuring yourself on purpose). Examples include: over-spending, risky sexual behaviour, substance abuse, reckless driving, binge eating, other _____ *(circle those that apply).*	1	2	3	4	5
12. Temper outbursts or problems with anger leading to relationship problems, physical fights, or destruction of property.	1	2	3	4	5

Circle the number which indicates how often you used the following positive behaviours in the last 30 days.

Please read the following statements and circle the response that best applies to you:

5 Almost always
4 Most of the time
3 Half of the time
2 Sometimes
1 Almost never

13. Choosing to use a positive activity in circumstances where you felt tempted to do something destructive or self-defeating.	5	4	3	2	1
14. Noticing ahead of time that something could cause you emotional difficulties and taking reasonable steps to avoid/prevent the problem.	5	4	3	2	1
15. Following through with therapy plans to which you agreed (e.g., talk therapy, "homework" assignments, coming to appointments, medications, etc.)	5	4	3	2	1

Appendix K

FFMQ

Please rate each of the following statements using the scale provided. Circle the number that best describes your own opinion of what is generally true for you.

1 Never or very rarely true
2 Rarely true
3 Sometimes true
4 Often true
5 Very often or always true

1. When I'm walking, I deliberately notice the sensations of my body moving.	1	2	3	4	5
2. I'm good at finding words to describe my feelings.	1	2	3	4	5
3. I criticise myself for having irrational or inappropriate emotions.	1	2	3	4	5
4. I perceive my feelings and emotions without having to react to them.	1	2	3	4	5
5. When I do things, my mind wanders off and I'm easily distracted.	1	2	3	4	5
6. When I take a shower or bath, I stay alert to the sensations of water on my body.	1	2	3	4	5
7. I can easily put my beliefs, opinions, and expectations into words.	1	2	3	4	5
8. I don't pay attention to what I'm doing because I'm daydreaming, worrying, or otherwise distracted.	1	2	3	4	5
9. I watch my feelings without getting lost in them.	1	2	3	4	5
10. I tell myself I shouldn't be feeling the way I'm feeling.	1	2	3	4	5
11. I notice how foods and drinks affect my thoughts, bodily sensations, and emotions.	1	2	3	4	5
12. It's hard for me to find the words to describe what I'm thinking.	1	2	3	4	5
13. I am easily distracted.	1	2	3	4	5

1 Never or very rarely true
2 Rarely true
3 Sometimes true
4 Often true
5 Very often or always true

14. I believe some of my thoughts are abnormal or bad and I shouldn't think that way.	1	2	3	4	5
15. I pay attention to sensations, such as the wind in my hair or sun on my face.	1	2	3	4	5
16. I have trouble thinking of the right words to express how I feel about things.	1	2	3	4	5
17. I make judgements about whether my thoughts are good or bad.	1	2	3	4	5
18. I find it difficult to stay focused on what's happening in the present.	1	2	3	4	5
19. When I have distressing thoughts or images, I "step back" and am aware of the thought or image without getting taken over by it.	1	2	3	4	5
20. I pay attention to sounds, such as clocks ticking birds chirping, or cars passing.	1	2	3	4	5
21. In difficult situations, I can pause without immediately reacting.	1	2	3	4	5
22. When I have sensations in my body, it's difficult for me to describe it because I can't find the right words.	1	2	3	4	5
23. It seems I am "running on automatic" without much awareness of what I'm doing.	1	2	3	4	5
24. When I have distressing thoughts or images, I feel calm soon after.	1	2	3	4	5
25. I tell myself that I shouldn't be thinking the way I'm thinking.	1	2	3	4	5
26. I notice the smells and aromas of things.	1	2	3	4	5
27. Even when I'm feeling terribly upset, I can find a way to put it into words.	1	2	3	4	5

1 Never or very rarely true
2 Rarely true
3 Sometimes true
4 Often true
5 Very often or always true

28. I rush through activities without being really attentive to them.	1	2	3	4	5
29. When I have distressing thoughts or images I am able to just notice them without reacting.	1	2	3	4	5
30. I think some of my emotions are bad or inappropriate and I shouldn't feel them.	1	2	3	4	5
31. I notice visual elements in art or nature, such as colours, shapes, textures, or patterns of light and shadow.	1	2	3	4	5
32. My natural tendency is to put my experiences into words.	1	2	3	4	5
33. When I have distressing thoughts or images, I just notice them and let them go.	1	2	3	4	5
34. I do jobs or tasks automatically without being aware of what I'm doing.	1	2	3	4	5
35. When I have distressing thoughts or images, I judge myself as good or bad, depending what the thought/image is about.	1	2	3	4	5
36. I pay attention to how my emotions affect my thoughts and behaviour.	1	2	3	4	5
37. I can usually describe how I feel at the moment in considerable detail.	1	2	3	4	5
38. I find myself doing things without paying attention.	1	2	3	4	5
39. I disapprove of myself when I have irrational ideas.	1	2	3	4	5

Appendix L

PRFQ-1

Listed below are a number of statements concerning you and your child. Read each item and decide whether you agree or disagree and to what extent.

Use the following rating scale, with 7 if you strongly agree; and 1 if you strongly disagree. The midpoint, if you are neutral or undecided, is 4.

Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree

_____ 1) My child and I can feel differently about the same thing.

_____ 2) When I get angry with my child, I always know the reason why.

_____ 3) I am often curious to find out how my child feels.

_____ 4) How I am feeling can affect how I understand my child's behaviour.

_____ 5) My child knows when I am having a bad day and does things to make it worse.

_____ 6) I like to think about the reasons behind the way my child behaves and feels.

_____ 7) I try to see situations through the eyes of my child.

_____ 8) I always know why my child acts the way he or she does.

_____ 9) My child sometimes gets sick to keep me from doing what I want to do.

_____ 10) I believe that how I think about my child will change over time.

_____ 11) My child can react to a situation very differently than I think he or she will.

_____ 12) I find it hard to actively participate in make believe play with my child.

_____ 13) At times, it takes several tries before I understand what my child needs or wants.

_____ 14) When my child is fussy he or she does that just to annoy me.

_____ 15) Now that I am a parent, I realise how my parents could have misunderstood my reactions when I was a child.

_____ 16) No matter how sick my child is, I can always tolerate him or her.

_____ 17) How I see my child changes as I change.

_____ 18) My behaviour towards my child cannot be explained by how I was raised.

_____ 19) I can always predict what my child will do.

_____ 20) I wonder a lot about what my child is thinking and feeling.

	Strongly Disagree	1	2	3	4	5	6	7	Strongly Agree

_____ 21) Often, my child's behaviour is too confusing to bother figuring out.

_____ 22) I can sometimes misunderstand the reactions of my child.

_____ 23) When my child is misbehaving it's a sign that he or she does not love me.

_____ 24) I believe that how my parents raised me affects how I raise my child.

_____ 25) My child cries around strangers to embarrass me.

_____ 26) I pay attention to what my child is feeling.

_____ 27) I can completely read my child's mind.

_____ 28) Understanding why my child behaves in a certain way helps me not to be upset with him or her.

_____ 29) I believe there is no point in trying to guess what my child feels.

_____ 30) I often think about how I felt when I was a child.

_____ 31) I try to understand the reasons why my child misbehaves.

_____ 32) I always know what my child wants.

_____ 33) I hate it when my child cries and/or talks to me when I am on the phone with someone.

_____ 34) The only time I'm certain my child loves me is when he or she is smiling at me.

_____ 35) I'm certain that my child knows that I love him or her.

_____ 36) The best way to know your child loves you is when he or she is well behaved.

_____ 37) My child's temperament is what it is, and there is little that I can do about that.

_____ 38) I always know why I do what I do to my child.

_____ 39) At times I get confused about what my child is feeling.

Appendix M

Difficulties in Emotion Regulation Scale (DERS)

Please indicate how often the following statements apply to you by writing the appropriate number from the scale below on the line beside each item.

1	2	3	4	5
almost never (0-10%)	sometimes (11-35%)	about half the time (36-65%)	most of the time (66-90%)	almost always (91-100%)

_____ 1) I am clear about my feelings.

_____ 2) I pay attention to how I feel.

_____ 3) I experience my emotions as overwhelming and out of control.

_____ 4) I have no idea how I am feeling.

_____ 5) I have difficulty making sense out of my feelings.

_____ 6) I am attentive to my feelings.

_____ 7) I know exactly how I am feeling.

_____ 8) I care about what I am feeling.

_____ 9) I am confused about how I feel.

_____ 10) When I'm upset, I acknowledge my emotions.

_____ 11) When I'm upset, I become angry with myself for feeling that way.

_____ 12) When I'm upset, I become embarrassed for feeling that way.

_____ 13) When I'm upset, I have difficulty getting work done.

_____ 14) When I'm upset, I become out of control.

_____ 15) When I'm upset, I believe that I will remain that way for a long time.

_____ 16) When I'm upset, I believe that I will end up feeling very depressed.

_____ 17) When I'm upset, I believe that my feelings are valid and important.

_____ 18) When I'm upset, I have difficulty focusing on other things.

_____ 19) When I'm upset, I feel out of control.

_____ 20) When I'm upset, I can still get things done.

_____ 21) When I'm upset, I feel ashamed at myself for feeling that way.

1----------2----------3----------4----------5

almost never	sometimes	about half the time	most of the time	almost always
(0-10%)	(11-35%)	(36-65%)	(66-90%)	(91-100%)

_____ 22) When I'm upset, I know that I can find a way to eventually feel better.

_____ 23) When I'm upset, I feel like I am weak.

_____ 24) When I'm upset, I feel like I can remain in control of my behaviors.

_____ 25) When I'm upset, I feel guilty for feeling that way.

_____ 26) When I'm upset, I have difficulty concentrating.

_____ 27) When I'm upset, I have difficulty controlling my behaviors.

_____ 28) When I'm upset, I believe there is nothing I can do to make myself feel better.

_____ 29) When I'm upset, I become irritated at myself for feeling that way.

_____ 30) When I'm upset, I start to feel very bad about myself.

_____ 31) When I'm upset, I believe that wallowing in it is all I can do.

_____ 32) When I'm upset, I lose control over my behavior.

_____ 33) When I'm upset, I have difficulty thinking about anything else.

_____ 34) When I'm upset I take time to figure out what I'm really feeling.

_____ 35) When I'm upset, it takes me a long time to feel better.

_____ 36) When I'm upset, my emotions feel overwhelming.

Appendix N

DSI

These are questions concerning your thoughts and feelings about yourself and relationships with others. Please read each statement carefully and decide how much the statement is generally true of you on a 1 (nor at all) to 6 (very) scale. If you believe that an item does not pertain to you (e.g., you are not currently married or in a committed relationship, or one or both of your parents are deceased), please answer the item according to your best guess about what your thoughts and feelings would be in that situation. Be sure to answer every item and try to be as honest and accurate as possible in your responses.

	Not at all true of me					Very true of me
1. People have remarked that I'm overly emotional.	1	2	3	4	5	6
2. I have difficulty expressing my feelings to people I care for.	1	2	3	4	5	6
3. I often feel inhibited around my family.	1	2	3	4	5	6
4. When someone close to me disappoints me, I withdraw from him or her for a time.	1	2	3	4	5	6
5. I tend to distance myself when people get too close to me.	1	2	3	4	5	6
6. I wish that I weren't so emotional.	1	2	3	4	5	6
7. My spouse or partner could not tolerate it if I were to express to him or her my true feelings about some things.	1	2	3	4	5	6
8. At times my feelings get the best of me and I have trouble thinking clearly.	1	2	3	4	5	6
9. I'm often uncomfortable when people get too close to me.	1	2	3	4	5	6
10. At times, I feel as if I'm riding an emotional roller coaster.	1	2	3	4	5	6
11. I'm concerned about losing my independence in intimate relationships.	1	2	3	4	5	6
12. I'm overly sensitive to criticism.	1	2	3	4	5	6
13. I often feel that my spouse or partner wants too much from me.	1	2	3	4	5	6
14. If I have had an argument with my spouse or partner, I tend to think about it all day.	1	2	3	4	5	6
15. When one of my relationships becomes very intense, I feel the urge to run away from it.	1	2	3	4	5	6
16. If someone is upset with me, I can't seem to let it go easily.	1	2	3	4	5	6
17. I would never consider turning to any of my family members for emotional support.	1	2	3	4	5	6
18. I'm very sensitive to being hurt by others.	1	2	3	4	5	6

	Not at all true of me					Very true of me
19. When I'm with my spouse or partner, I often feel smothered.	1	2	3	4	5	6
20. I often wonder about the kind of impression I create.	1	2	3	4	5	6
21. When things go wrong, talking about them usually makes it worse.	1	2	3	4	5	6
22. I feel things more intensely than others do.	1	2	3	4	5	6
23. Our relationship might be better if my spouse or partner would give me the space I need.	1	2	3	4	5	6

Appendix O

PSI

Read each statement carefully. For each statement, please focus on the child you are most concerned about, and circle the response which best represents your opinion.

Circle the SA if you strongly agree with the statement.
Circle the A if you agree with the statement.
Circle the NS if you are not sure.
Circle the D if you disagree with the statement.
Circle the SD if you strongly disagree with the statement.

For example, if you sometimes enjoy going to the movies, you would circle A in response to the following statement:

I enjoy going to the movies SA (A) NS D SD

While you may not find a response that exactly states your feelings, please circle the response that comes closest to describing how you feel. YOUR FIRST REACTION TO EACH QUESTION SHOULD BE YOUR ANSWER.

Circle only one response for each statement, and respond to all statements. If you need to change an answer, make an X through the incorrect answer and circle the correct response.

SA = Strongly Agree A = Agree NS = Not Sure D = Disagree SD = Strongly Disagree

1. When my child came home from the hospital, I had doubtful feelings about my ability to handle being a parent.	SA A NS D SD
2. Being a parent is harder than I thought it would be.	SA A NS D SD
3. I feel capable and on top of things when I am caring for my child.	SA A NS D SD
4. I can't make decisions without help.	SA A NS D SD
5. I have had many more problems raising children than I expected.	SA A NS D SD
6. I enjoy being a parent.	SA A NS D SD
7. I feel that I am successful most of the time when I try to get my child to do or not do something.	SA A NS D SD
9. I often have the feeling that I cannot handle things very well.	SA A NS D SD

For statement 10, choose from choices 1 to 5 below.

10. When I think about myself as a parent I believe:
    1. I can handle anything that happens.
    2. I can handle most things pretty well.
    3. Sometimes I have doubts, but I find that I handle most things without any problems.
    4. I have some doubts about being able to handle things.
    5. I don't think I handle things well at all.

For statement 11, choose from choices 1 to 5 below.

11. I feel that I am:
    1. A very good parent.
    2. A better than average parent.
    3. An average parent.
    4. A person who has some trouble being a parent.
    5. Not very good at being a parent.

For questions 12 and 13, choose from choices 1 to 5 below.

12. What were the highest levels in school or college you and the child's father have completed?

    Mother:
    1. 1st to 8th grade.
    2. 9th to 12th grade.
    3. Vocational or some college.
    4. College graduate.
    5. Graduate or professional school.

13. Father:
    1. 1st to 8th grade.
    2. 9th to 12th grade.
    3. Vocational or some college.
    4. College graduate.
    5. Graduate or professional school.

For question 14, choose from choices 1 to 5 below.

14. How easy is it for you to understand what your child wants or needs?
    1. Very easy.
    2. Easy.
    3. Somewhat difficult.
    4. It is very hard.
    5. I usually can't figure out what the problem is.

SA = Strongly Agree A = Agree NS = Not Sure D = Disagree SD = Strongly Disagree

15. It takes a long time for parents to develop close, warm feelings for their children.	SA A NS D SD
16. I expected to have closer and warmer feelings for my child than I do and this bothers me.	SA A NS D SD
17. Sometimes my child does things that bother me just to be mean.	SA A NS D SD
18. When I was young, I never felt comfortable holding or taking care of children.	SA A NS D SD
19. My child knows I am his or her parent and wants me more than other people.	SA A NS D SD
20. The number of children that I have now is too many.	SA A NS D SD
21. Most of my life is spent doing things for my child.	SA A NS D SD
22. I find myself giving up more of my life to meet my children's needs than I ever expected.	SA A NS D SD
23. I feel trapped by my responsibilities as a parent.	SA A NS D SD
24. I often feel that my child's needs control my life.	SA A NS D SD
25. Since having this child, I have been unable to do new and different things.	SA A NS D SD
26. Since having a child, I feel that I am almost never able to do things that I like to do.	SA A NS D SD
27. It is hard to find a place in our home where I can go to be by myself.	SA A NS D SD
28. I feel alone and without friends.	SA A NS D SD
29. When I go to a party, I usually expect not to enjoy myself.	SA A NS D SD
30. I am not as interested in people as I used to be.	SA A NS D SD

SA = Strongly Agree A = Agree NS = Not Sure D = Disagree SD = Strongly Disagree

31. I often have the feeling that other people my own age don't particularly like my company.	SA A NS D SD
32. When I run into a problem taking care of my children, I have a lot of people to whom I can talk to get help or advice.	SA A NS D SD
33. Since having children, I have a lot fewer chances to see my friends and to make new friends.	SA A NS D SD

Appendix P

DASS21

Name: *Date:*

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

Appendix Q

Experiences in Close Relationship Scale-Short Form (ECR-S)

Instruction: The following statements concern how you feel in romantic relationships. We are interested in how you generally experience relationships, not just in what is happening in a current relationship. Respond to each statement by indicating how much you agree or disagree with it. Mark your answer using the following rating scale:

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Slightly Disagree	Neutral	Slightly Agree	Agree	Strongly Agree

1. It helps to turn to my romantic partner in times of need.
2. I need a lot of reassurance that I am loved by my partner.
3. I want to get close to my partner, but I keep pulling back.
4. I find that my partner(s) don't want to get as close as I would like.
5. I turn to my partner for many things, including comfort and reassurance.
6. My desire to be very close sometimes scares people away.
7. I try to avoid getting too close to my partner.
8. I do not often worry about being abandoned.
9. I usually discuss my problems and concerns with my partner.
10. I get frustrated if romantic partners are not available when I need them.
11. I am nervous when partners get too close to me.
12. I worry that romantic partners won't care about me as much as I care about them.

Appendix R

Relationship Questionnaire

1. Following are descriptions of four general relationship styles that people often report.

Please read each description and **CIRCLE** the letter corresponding to the style that *best* describes you or is *closest* to the way you generally are in your close relationships.

A. It is easy for me to become emotionally close to others. I am comfortable depending on them and having them depend on me. I don't worry about being alone or having others not accept me.

B. I am uncomfortable getting close to others. I want emotionally close relationships, but I find it difficult to trust others completely, or to depend on them. I worry that I will be hurt if I allow myself to become too close to others.

C. I want to be completely emotionally intimate with others, but I often find that others are reluctant to get as close as I would like. I am uncomfortable being without close relationships, but I sometimes worry that others don't value me as much as I value them.

D. I am comfortable without close emotional relationships. It is very important to me to feel independent and self-sufficient, and I prefer not to depend on others or have others depend on me.

Appendix S

Pre-Program Interview Schedule

1. What are the most challenging things about being a Mum?
2. What surprised you the most about being a Mum?
3. What would you love to not have to do?
4. What would you change if you could?
5. What gives you the greatest enjoyment about being a mum?
6. What is your general experience of being a mother?
7. What was your mum like as a parent when you were a child?
8. What was your dad like as a parent when you were a child?
9. How similar or different are you as a mum compared to your parents?
10. What do you imagine your son/daughter would say about you as a mum, if she /he could talk?
11. What would you like her/him to say now and in the future?
12. What are five words that best describe how you feel about being a parent/mum?
13. How do you think your partner would describe you as a parent/mum?
14. What's the best and worst thing about being a mum for you?
15. What do you think is the ideal mum?
16. How do you see yourself as a mum in relation to that ideal?
17. What, for you, is the mum you don't want to be?
18. What do you think of the idea of the good enough mum?
19. How do you see yourself in relation to the good enough mum?

20. Can you tell me about an interaction with your child that has been the low point for you as a mum?

21. Can you tell me about an interaction with your child that has been the high point for you as a mum?

22. Can you tell me about an incident when you were a child that was a low point with your own mother? *Age and details?*

23. Can you tell me about an incident when you were a child that was a high point with your own mother? *Age and details?*

24. Can you tell me about an incident when you were a child that was a low point with your own father? *Age and details?*

25. Can you tell me about an incident when you were a child that was a high point with your own father? *Age and details?*

Appendix T

Post-Program Interview Schedule

1. Have things changed for you as a mum since starting the group?
    - What has changed for you as a mum?

2. Since starting the group, have things changed for you in your life generally?
    - What has changed for you?

3. Are there things that you found challenging about being a mum before starting the group that you find less challenging now?
    - Do you feel that you deal with these things better now?
    - How do you deal with these things differently?

4. Since starting the group, have you noticed any changes in how much you enjoy being a mum?

5. Since starting the group has your experience of being a mother changed?
    - Have you found your experience as a mother to be better or worse since starting the group?

6. Have you noticed any changes in your relationships with your children since starting the group?

If they have a husband:

7. Have you noticed any changes in your relationship with your husband since starting the group?

8. Have you noticed any changes in your relationships with your family since starting the group?

9. Have you noticed any changes in other relationships since starting the group?

10. Have you noticed any changes in how you parent since starting the group?

11. Since starting the group, have you noticed any changes in the thoughts that you have about being a mother?

12. Have you noticed any changes in your self-evaluations since the group began?

13. What are five words that best describe how you feel about being a mum?

14. What is the best thing about being a mum for you?

15. What is the worst thing about being a mum for you?

16. How do you see yourself in relation to the good enough mum?

17. How would you describe your experience of the mindfulness practice outside of the group?

18. Have you noticed any differences in how mindful you are since the group began?

19. Have you noticed any changes in your mood since starting the group?

20. Have you noticed any changes in how you manage difficult thoughts since you started the group?

21. Have you noticed any changes in how you manage difficult emotions since you started the group?

22. Can you think about a time since you started the group when difficult emotions have come up?
    - What were the emotions?
    - What thoughts did you have?
    - What did you do?

23. Can you tell me about a time since you started the group where you feel that you weren't able to use mindfulness or other coping skills?
    - What were the barriers to using mindfulness?
    - What were the barriers to using other coping skills?
      e.g. Support, emotions, thoughts, beliefs.

24. Can you tell me about a time since you started the group where you feel that you used mindfulness or other coping skills effectively?
    - Was it easier to use these skills in this situation?
    - What was different for you that made it easier to use these skills?
    - E.g. Support, emotions, thoughts, beliefs.

25. Can you tell me about an interaction with your child that has been a low point for you as a mum since you started the group?

26. Can you tell me about an interaction with your child that has been a high point for you as a mum since you started the group?

27. Can you tell me about an interaction with your husband/parent/friend (someone close) that has been a low point for you since you started the group?

28. Can you tell me about an interaction with your husband/parent/friend (someone close) that has been a high point for you since you started the group?

Appendix U

SESSION FEEDBACK QUESTIONNAIRE

Name: _____

Please reflect on your experience of today's session and answer the following questions. There are no right or wrong answers. We appreciate your honest feedback.

1. Rate how useful/relevant you feel the activities/discussions today were for you and your concerns.

1	2	3	4	5	6	7	8	9	10
Not relevant at all				Moderately relevant					Highly relevant

What was the most useful/ relevant part of today's session?

2. Rate how helpful you feel mindfulness will be for you as a mother.

1	2	3	4	5	6	7	8	9	10
Not helpful at all				Moderately helpful					Highly helpful

3. Rate how helpful you feel mindfulness will be for you in your life generally.

1	2	3	4	5	6	7	8	9	10
Not helpful at all				Moderately helpful					Highly helpful

4. How much did you like today's mindfulness practice (exercise 1)?

1	2	3	4	5	6	7	8	9	10
Not at all				Somewhat					A lot

How much did you like today's mindfulness practice (exercise 2)?

1	2	3	4	5	6	7	8	9	10
Not at all				Somewhat					A lot

5. How often did you practice mindfulness in the last week?

6. What was the most enjoyable part of today's session?

7. What do you think could have improved today's session?

Thank you

SWINBURNE UNIVERSITY OF TECHNOLOGY

Appendix V

MINDFULNESS PARENTING GROUP FEEDBACK QUESTIONNAIRE

Name: _____

Please reflect on your experiences of the 12 sessions and answer the following questions. There are no right or wrong answers. We appreciate your honest feedback.

1. Rate how helpful do you feel the activities and discussions were for you and your concerns

Activities:

1	2	3	4	5	6	7	8	9	10
Not helpful at all				Moderately helpful					Highly helpful

Discussions:

1	2	3	4	5	6	7	8	9	10
Not helpful at all				Moderately helpful					Highly helpful

2. Which session/s did you find the most helpful?

3. What did you find most helpful about these sessions?

4. What was the most enjoyable part of the group?

5. What do you think could have improved the group?

6. Have you noticed any changes for you since the group began?

7. How helpful do you find mindfulness to be for you as a mother?

1	2	3	4	5	6	7	8	9	10
Not helpful at all				Moderately helpful					Highly helpful

8. How helpful do you find mindfulness to be for you in your life generally?

1	2	3	4	5	6	7	8	9	10
Not helpful at all				Moderately helpful					Highly helpful

9. How often did you practice mindfulness <u>before attending the group</u>?

Not at all	Once a month or less	Once a week or less	2-4 times a week	5-7 days a week	More than once a day

10. How often you <u>currently</u> practice mindfulness?

Not at all	Once a month or less	Once a week or less	2-4 times a week	5-7 days a week	More than once a day

Thank you

Appendix W

FOCUS GROUP QUESTIONS FOR DISCUSSION

1. Looking back, what do you think of the group program overall?

2. What were you hoping to get out of the group when it began?
3. Did what you wanted to get out of the group change over the 12 weeks?

4. What do you feel you have gotten from the group?
5. What impact has the group had on you as an individual and as a parent?

6. Topics:
    a. Most helpful?
    b. Least helpful?
    c. What else would you have liked to be covered in the group?

7. What are your thoughts about:
    a. Length of sessions, length of program – do you think the program should run for longer?
    b. Timing
    c. Resources and materials
    d. Facilitators

8. Was there enough practical parenting content in the group?
    a. <u>If no</u>: If the group had more parenting content, it would be likely to run longer, would that improve the program?

9. What could we have changed to make the group more helpful for you?
10. If you were coordinating the group, what would you do differently?

11. Who would the group suit? Who wouldn't suit the group?
    a. How could we advertise the program to these people?

12. Where to now?
    a. Would booster sessions be helpful?
    b. How many would you suggest?
    c. What could be useful to cover in these?

13. In your parenting journey, what else would be helpful, both within the group and outside the group?

14. Is there anything else that would be helpful for us to know?

Appendix X
Ethics Approvals

From: resethics@swin.edu.au [mailto:resethics@swin.edu.au]
Sent: Friday, 21 August 2015 7:57 AM
To: Roslyn Galligan
Cc: RES Ethics
Subject: Acknowledgement of Report for SUHREC Project - 2012/111

Dear Roslyn Galligan,

Re: Final Report for the project (Report Date: 20-08-2015)

2012/111 'Pilot of a Mindfulness-Based Parenting Program for Mothers with Borderline Personality Disorder (BPD).'

The Final report for the above project (Report Date: 20-08-2015) has been processed and satisfies the reporting requirements set under the terms of ethics clearance.

Research Ethics Team

Swinburne Research (H68)
Swinburne University of Technology
PO Box 218
HAWTHORN VIC 3122
Tel: 03 9214 5218
Fax: 03 9214 5267
Email: resethics@swin.edu.au

From: Keith Wilkins
Sent: Friday, 7 March 2014 6:17 PM
To: Roslyn Galligan
Cc: RES Ethics; Natasha Rogers
Subject: SUHREC Project 2012/111 Ethics Clearance for Modifications/Extension (4)

To: Dr Roslyn Galligan, FHAD

Dear Roslyn and Natasha

SUHREC Project 2012/111 Pilot of a Mindfulness-Based Parenting Program for Mothers with Borderline Personality Disorder (BPD).
Dr Roslyn Galligan, FHAD; Ms Natasha Rogers et al
Approved Duration: 26/10/2012 To 31/01/2014 [Modified April 2013; April 2013; May 2013; March 2014]

I refer to your request for a modification to the protocol and an extension of ethics clearance as per your email of 5 March 2014 with attachments. The request, concerning additional recruitment arrangements, was put to a SUHREC delegate for consideration and feedback sent to you. Your responses to the feedback, as emailed today with attached revised consent instrument, accord with the delegate's feedback.

I am pleased to advise that, as modified to date, the project may continue in line with ethics clearance conditions previously communicated and reprinted below.

Please contact the Research Ethics Office if you have any queries about on-going ethics clearance, citing the SUHREC project number. Copies of clearance emails should be retained as part of project record-keeping.

As before, best wishes for the project.

Yours sincerely,

Keith

Keith Wilkins
Secretary, SUHREC & Research Ethics Officer
Swinburne Research (H68)
Swinburne University of Technology
P O Box 218
HAWTHORN VIC 3122
Tel +61 3 9214 5218
Fax +61 3 9214 5267

From: Sheila Hamilton-Brown
Sent: Wednesday, 22 May 2013 9:36 AM
To: Roslyn Galligan; Natasha Rogers
Cc: RES Ethics; FLSS Research
Subject: SUHREC Project 2012/111 Ethics Clearance for Modification/Extension (3)

To: Dr Roslyn Galligan, FLSS
Ms Natasha Rogers

Dear Roslyn and Natasha

SUHREC Project 2012/111 Pilot of a Mindfulness-Based Parenting Program for Mothers with Borderline Personality Disorder (BPD).
Dr Roslyn Galligan, Ms Natasha Rogers; FLSS
Approved Duration: 26/10/2012 To 31/01/2014 [Modified April 2013; April 2013; May 2013]

I refer to your request for a modification to the protocol as per your email of 14 May 2013 in which you request modification of the project as regards recruitment. The request was put to a SUHREC delegate for consideration.

I am pleased to advise that the project may continue in line with standard on-going ethics clearance conditions previously communicated and reprinted below.

Please note that you will need to ensure you maintain the highest security settings and advise participants of Facebook's privacy policy.

Please contact the Research Ethics Office if you have any queries about on-going ethics clearance, citing the SUHREC project number. Copies of clearance emails should be retained as part of project record-keeping.

As before, best wishes for the project.

Yours sincerely,

Sheila
for Keith Wilkins
Secretary, SUHREC

From: Sheila Hamilton-Brown
Sent: Friday, 26 April 2013 11:46 AM
To: Roslyn Galligan; Natasha Rogers
Cc: RES Ethics
Subject: SUHREC Project 2012/111 Ethics Clearance for Modification/Extension (2)

To: Dr Roslyn Galligan, FLSS
Ms Natasha Rogers

Dear Roslyn and Natasha

SUHREC Project 2012/111 Pilot of a Mindfulness-Based Parenting Program for Mothers with Borderline Personality Disorder (BPD).
Dr Roslyn Galligan, Ms Natasha Rogers; FLSS
Approved Duration: 26/10/2012 To 31/01/2014 [Modified April 2013; April 2013]

I refer to your request for a modification to the protocol as per your email of 23 April 2013, with further clarification on 26 April 2013, in which you request an extension to the duration of the project.

There being no change to the approved protocol, I am authorised to issue the extension of ethics clearance in line with standard on-going ethics clearance conditions previously communicated and reprinted below.

Please contact the Research Ethics Office if you have any queries about on-going ethics clearance, citing the SUHREC project number. Copies of clearance emails should be retained as part of project record-keeping.

As before, best wishes for the project.

Yours sincerely,

Sheila
for Keith Wilkins
Secretary, SUHREC

From: Sheila Hamilton-Brown
Sent: Tuesday, 9 April 2013 11:45 AM
To: Roslyn Galligan; Natasha Rogers
Cc: RES Ethics
Subject: SUHREC Project 2012/111 Ethics Clearance for Modification/Extension (1)

To: Dr Roslyn Galligan, FLSS
Ms Natasha Rogers

Dear Roslyn and Natasha

SUHREC Project 2012/111 Pilot of a Mindfulness-Based Parenting Program for Mothers with Borderline Personality Disorder (BPD).
Dr Roslyn Galligan, Ms Natasha Rogers; FLSS
Approved Duration: 26/10/2012 To 30/06/2013 [Modified April 2013]

I refer to your request for a modification to the protocol as per your email of 21 March 2013 with attachments. The request was put to a SUHREC delegate for consideration.

I am pleased to advise that the project may continue in line with standard on-going ethics clearance conditions previously communicated and reprinted below.

Please contact the Research Ethics Office if you have any queries about on-going ethics clearance, citing the SUHREC project number. Copies of clearance emails should be retained as part of project record-keeping.

As before, best wishes for the project.

Yours sincerely,

Sheila
for Keith Wilkins
Secretary, SUHREC

From: Sheila Hamilton-Brown
Sent: Friday, 26 October 2012 11:24 AM
To: Roslyn Galligan; Natasha Rogers
Cc: RES Ethics; FLSS Research
Subject: SUHREC Project 2012/111 Ethics Clearance

To: Dr Roslyn Galligan, FLSS
Ms Natasha Rogers

Dear Roslyn and Natasha

SUHREC Project 2012/111 Pilot of a Mindfulness-Based Parenting Program for Mothers with Borderline Personality Disorder (BPD).
Dr Roslyn Galligan, Ms Natasha Rogers; FLSS
Approved Duration: 26/10/2012 To 30/06/2013 [Adjusted]

I refer to the ethical review of the above project protocol by Swinburne's Human Research Ethics Committee (SUHREC). The responses to the review, as emailed on 14 September 2012 (with attachments including revised consent instruments and advertisement), were put to a SUHREC delegate for consideration and feedback sent to you. Your response, as emailed on 10 October 2012 (with changes to the original protocol), accords with the feedback.

I am pleased to advise that, as submitted to date, the project may proceed in line with standard on-going ethics clearance conditions here outlined.

- All human research activity undertaken under Swinburne auspices must conform to Swinburne and external regulatory standards, including the *National Statement on Ethical Conduct in Human Research* and with respect to secure data use, retention and disposal.

- The named Swinburne Chief Investigator/Supervisor remains responsible for any personnel appointed to or associated with the project being made aware of ethics clearance conditions, including research and consent procedures or instruments approved. Any change in chief investigator/supervisor requires timely notification and SUHREC endorsement.

- The above project has been approved as submitted for ethical review by or on behalf of SUHREC. Amendments to approved procedures or instruments ordinarily require prior ethical appraisal/ clearance. SUHREC must be notified immediately or as soon as possible thereafter of (a) any serious or unexpected adverse effects on participants and any redress measures; (b) proposed changes in protocols; and (c) unforeseen events which might affect continued ethical acceptability of the project.

- At a minimum, an annual report on the progress of the project is required as well as at the conclusion (or abandonment) of the project.

- A duly authorised external or internal audit of the project may be undertaken at any time.

Please contact the Research Ethics Office if you have any queries about on-going ethics clearance, citing the SUHREC project number. Copies of clearance emails should be retained as part of project record-keeping.

Best wishes for the project.

Yours sincerely

Sheila
for Keith Wilkins
Secretary, SUHREC

****

Sheila Hamilton-Brown
Administrative Officer (Research Ethics & Biosafety)
(Tues, Wed & Fri)
Swinburne Research (H68)
Swinburne University of Technology
PO Box 218
HAWTHORN VIC 3122
Tel: 03 9214 5935
Fax: 03 9214 5267

From: Sheila Hamilton-Brown
Sent: Wednesday, 19 September 2012 10:02 AM
To: Roslyn Galligan; Natasha Rogers
Cc: RES Ethics
Subject: SUHREC Project 2012/111 Ethics Clearance Forthcoming

To: Dr Roslyn Galligan, FLSS
Ms Natasha Rogers

Dear Roslyn and Natasha

SUHREC Project 2012/111 Pilot of a Mindfulness-Based Parenting Program for Mothers with Borderline Personality Disorder (BPD).
Dr Roslyn Galligan, Ms Natasha Rogers; FLSS
Proposed Duration: 01/08/2012 To 01/04/2013

Your responses to the ethical review of the above project protocol was undertaken by SUHREC delegate(s) and I am pleased to advise have for the most part been approved. However, the following points were thought to need further attention to enable clearance to be issued:

1. Clarification of the role of supervisor, Katie Wyman of Spectrum in the project. NB: This will need to be correlated with the relevant sections in the protocol including but not limited to "Other chief/Associate Investigators and RA" (Page 1), A8, A10/A11, C6/C7 and the consent instruments. If Katie Wyman has not yet been approved/confirmed as Supervisor before clearance is issued, this can be done on a Progress/Final/Extension of Ethics Clearance form found on http://www.research.swinburne.edu.au/ethics/forms/

2. Clarification of the involvement of the other provisional psychologist mentioned in A2. Details will need to be supplied as per comments in 1 above if the provision psychologist is accessing data etc..

Please respond to the above by return e-mail with attachments including consent instruments where applicable.

Please also note that human research activity (including active participant recruitment) cannot commence before proper ethics clearance is given in writing.

Please contact the Research Ethics Office if you have any queries about the ethical review process undertaken, citing the SUHREC project number.

Kind regards,

Sheila Hamilton-Brown for
Keith Wilkins
Secretary, SUHREC

****

Sheila Hamilton-Brown
Administrative Officer (Research Ethics & Biosafety)
(Tues, Wed & Fri)
Swinburne Research (H68)
Swinburne University of Technology
PO Box 218
HAWTHORN VIC 3122
Tel: 03 9214 5935
Fax: 03 9214 5267

From: Resethics [mailto:Resethics@groupwise.swin.edu.au]
Sent: Wednesday, 13 June 2012 9:27 AM
To: Galligan, Roslyn; Rogers, Natasha
Cc: Sheila Hamilton-Brown; Resethics
Subject: SUHREC Project 2012/111 Ethical Review
Importance: High

To: Dr Roslyn Galligan, FLSS
Ms Natasha Rogers

Dear Roslyn and Natasha

SUHREC Project 2012/111 Pilot of a Mindfulness-Based Parenting Program for Mothers with Borderline Personality Disorder (BPD).
Dr Roslyn Galligan, FLSS, Ms Natasha Rogers Proposed Duration: 01/08/2012 To 01/04/2013

Ethical review of the above project protocol was undertaken by Swinburne's Human Research Ethics Committee (SUHREC) at its Meeting 04/2012 held 25 May 2012, the outcome of which as follows.
Approved subject to the following addressed to Acting Chair's (or delegate's) satisfaction in a revised application using track changes:

1) The Committee seeks clarification of the many potential benefits of the program listed in the Information statement and Advert/Flyer as they may be considered an unfair inducement.

2) A1: Clarification of this section sought, including a copy of the planned intervention program detailing project aims and what the project requires of participants.

3) A3: clear statement of the total time commitment required (cf Information Statement); for 2nd para under Semi-Structured Interview (also refer A4 below) clarification needed as to what 'data' are being accessed.

4) A4: "Information about participant's previous and current therapeutic treatment….program".. -clarification needed of the mechanism for accessing the data, and the need for this access to be an explicit detail for consent purposes, including the consent form.

5) A11 (cf. A3): clarification required for why no approvals needed for in-patients at the Melbourne and Albert Road clinics.

6) C3: BPD should have been given as a pre-existing condition.

7) Information Statement (IS): indication needed that Natasha Rogers is a Student Researcher (Investigator). Outline in both the IS and advert/flyer that there will be 16 sessions in the program.

8) Consent Form: to be clear to participants that they are agreeing to participate in an entire program (of considerable length), not just interviews or complete questionnaires.

9) This demanding intervention project is not costing participants, yet another demanding intervention project of the supervisor considered at the above SUHREC meeting is costing participants (SUHREC Project 2012/108); if costs are justified there, why not here?

In this instance, please could you submit a revised submission with tracked changes, and include a cover statement addressing the above as applicable. Attach proposed or revised consent/publicity/other instruments in light of the above (if available, converting these documents to pdf before submission will save disk space).
Please note that human research activity (including active participant recruitment) cannot commence before proper ethics clearance is given in writing.

Please contact the Research Ethics Office if you have any queries about the ethical review process undertaken, citing the SUHREC project number.

Yours sincerely

Sheila Hamilton-Brown for
Keith Wilkins
Secretary, SUHREC

Appendix Y

Circle of Security License Agreement

Circle of Security
INTERNATIONAL
Early Intervention Programs for Parents & Children

Circle of Security® License Agreement

This License Agreement is entered into as of October 15 2015 by and between Cooper, Hoffman, Powell LLC, with a principle place of business at 35 W Main STE 313; Spokane, Washington, 99201; USA and Licensee Natasha Rogers & Roslyn Galligan, Swinburne University, John Street, Hawthorn, Victoria, Australia, 3122.

DELIVERY.

Licensee may use the following Circle of Security Graphics in the publication: *Mindful Parenting Group Intervention for Mothers with Borderline Personality Disorder Traits: Program Development and Evaluation. The graphics will be sent to Natasha rogers & Roslyn Galligan and must be used in its entirety without any changes except font size.*

1. COS 25 Words or less
2. COS Original Circle
3. COS In a Chaotic World
4. COS Circle of Repair
5. COS Note to Parents
6. Travelling Around COS
7. COS Time In

LICENSE GRANT. Subject to all terms of this Agreement, Licensor grants Licensee a limited, non-exclusive, non-transferable, non-sublicensable right to use the specified *Circle of Security Graphics*. No materials from COS can be used in any publication without written consent from Circle of Security International."

RESERVATION; LIMITATIONS. The Materials are owned solely by Licensor and protected by copyright and other intellectual property laws and treaties. Licensor retains all rights in the Materials, except for the rights expressly granted and does not grant Licensee any other licenses or intellectual property rights. Without limiting the foregoing, Licensee may not (without Licensor's express, prior, written consent): (a) copy, modify, rent, lease, lend, or otherwise transfer the Materials or any rights in the Materials; or (b) use the "Circle of Security" on the cover or title page of the book or in any synopsis of the book (c) use the name Circle of Security in promotion material or advertising the Book (d) claim that using the Circle of Security graphic in any way makes the book or other materials in the book evidence based because of the research completed on the Circle of Security. The Materials are licensed, not sold.

1 TERM AND TERMINATION.

(a) *Term.* The term of this Agreement ("Term") commences on the February 1, 2009 and continues in perpetuity unless terminated according to the provisions of this document.

(b) *Termination.* Licensee may terminate this Agreement at any time by returning all copies of the Materials. In addition, either party may terminate this Agreement immediately on notice at any time if the other party is in material breach of this Agreement and has failed to cure that breach within 30 days after notice. Upon termination of this Agreement, Licensee will return to Licensor all copies of the Materials that are in Licensee's possession or control. Neither party will be liable to the other for damages resulting solely from terminating this Agreement in accordance with its terms.

2 SURVIVAL. The following provisions will survive any termination of this Agreement:

(a) Warranty disclaimers. Licensor makes no warranties of any kind (express, implied, or otherwise), including implied warranties of merchantability, fitness for a particular purpose, title, or non-infringement, with respect to its performance or any materials or services provided to licensee in relation to this agreement,

and the entire risk as to licensee's performance and any such materials and services is assumed by licensee. Without limiting the foregoing, licensor makes no representations or warranties as

(b) to the accuracy, completeness, or quality of the materials, and licensee's use thereof and reliance thereon is at licensee's sole risk.

(c) Exclusion of certain damages. Neither party will be liable for any indirect, consequential, special, incidental, or punitive damages related to this agreement, even if such party has been advised of

the possibility of such damages in advance and even if any remedy fails of its essential purpose, regardless of the form of action and regardless of the legal theory on which liability is predicated. This does not apply, however, to licensee's breach of licensee's infringement or misappropriation of licensor's intellectual property or other proprietary rights.

3 GENERAL.

(a) *Governing Law; Venue.* This Agreement is subject to Washington law, and the exclusive jurisdiction and venue for any dispute related to it is in the state and federal courts in Spokane County, Washington (and each party waives its right to assert that these courts do not have personal jurisdiction over it or are an inconvenient forum). In any action to enforce or interpret this Agreement (e.g., a lawsuit for breach), the prevailing party may recover its costs, including reasonable attorneys' fees

(b) *Miscellaneous.* Licensee may not assign this Agreement without Licensor's consent (and any attempted assignment without consent is void). To be effective, a waiver of any breach of this Agreement must be in a writing that refers to a particular breach, which will waive liability only for that breach. Each party will pay all of its own costs to perform, except if otherwise stated in this Agreement. All rights and remedies under this Agreement are cumulative. This Agreement may be executed in counterparts and by fax. In performing this Agreement, each party will comply with all applicable laws. The parties are independent contractors, and this Agreement does not create any other relationship (e.g., no partnership or agency is formed).

(c) *Entire Agreement.* This is the entire agreement between Licensor and Licensee concerning the Materials, and it supersedes any prior and contemporaneous communications, and any prior agreements, written or oral, concerning that subject matter. This Agreement cannot be amended except by a writing (not including electronic mail) dated after the Effective Date and manually signed on behalf of all parties by their respective duly authorized representatives.

The parties have formed this Agreement as of the Effective Date.

COOPER HOFFMAN & POWELL LLC	"LICENSEE"
By: (Sign) Glen Cooper	By: (Sign) ROSLYN GALLAND NATASHA ROGERS
Name: (Print) Co-Originator	Name: DR. Ms.
Title: 11/13/2015	Title: 5/4/2015 11/4/15
Date of Signing:	Date of Signing: