Perinatal Mental Health Staff Experiences of Working with Mothers Diagnosed with Emotionally Unstable Personality Disorder

Brogan Algar

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School of Health and Social Care
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Abstract

Background: When women diagnosed with Emotionally Unstable Personality Disorder (EUPD) become mothers, much of the research has focused on the psychological outcomes of their children. Currently, there is very little evidence into how these mothers respond to perinatal mental health services and no research in the United Kingdom exploring how perinatal mental health staff engage with mothers who have this diagnosis.

Aim: The aim of this research was to explore how perinatal mental health staff work effectively with mothers who have an EUPD diagnosis and to ascertain their views on the adequacy of perinatal service provision for women who have this diagnosis.

Method: Reflexive Thematic Analysis was used to analyse the experiences of 13 perinatal mental health staff who engaged in semi-structured interviews. Staff were recruited from three NHS trusts in England.

Results: Six themes and 13 subthemes were identified: Let’s Talk About Labels; We’re in This Together – The Work is Relational; The Fit Between Staff and Service; The Importance of Feeling Valued; Trying to Navigate a Complex System; Where Does the Responsibility Lie?

Conclusion: The results of this study have highlighted the ways in which perinatal staff feel they work effectively with mothers who have an EUPD diagnosis, namely through relational working. Furthermore, it has highlighted the social, organisational and systemic influences which staff feel impact perinatal service provision for women with an EUPD diagnosis. As a result of these findings, numerous clinical implications and recommendations have been made.

Introduction

1.1 Chapter Summary

This chapter provides the introductory context for the present study by reviewing the construct of a personality disorder diagnosis. It will recognise the application of the diagnosis within the United Kingdom (UK), particularly within the National Health Service (NHS), whilst remaining critical of its use. In particular, the history of the diagnosis, the biopsychosocial theories that have been attributed to its cause and diagnostic critiques will be outlined. The latter half of the chapter will then introduce the concept of perinatal mental health. This will include the definition of perinatal services, the history of these services and the current UK policy guidelines for perinatal support, specifically for women with a diagnosis of personality disorder. It will then present the findings of a systematic literature review investigating mental health nurses' experiences of effective practice with this client group. The research aims of the current study will be addressed.

1.2 Personality Disorder

1.2.1 History of Personality Disorders

The evolution of personality dates back to 551-479 BCE Chinese and Greek philosophy where it was thought that the combination of blood and vital essence affects temperament (Lo, 2004). The term personality has been used since the 18th century to define an individual's qualities (Lo, 2004). This was around the same time that psychiatry took precedence as a modern science (Crocq, 2013). In 1921, German psychiatrist Emil Kraepelin identified the diagnosis of 'excitable personality' which has many similarities to the typical personality disorder diagnoses seen today (Millon, 1996). A decade later the term 'borderline' was introduced to psychiatry by American psychoanalyst Adolph Stern (Stern, 1938). The term borderline was used to classify individuals who sat on the border between neurosis and psychosis, indicating a ‘mild schizophrenia’. From this point onwards in the 1960s and 1970s, the term borderline was transforming in its applications to a word used to describe mood disorders, notably borderline affective disorder. In 1967, psychoanalyst Otto Kernberg was the first known individual to refer to borderline as a personality trait (Gunderson, 2009). He too felt it described an individual who sat between psychosis and neurosis, but rather than being schizophrenic in nature, he viewed it as part of an individual’s personality. Kernberg’s views ultimately influenced the diagnosis of borderline personality disorder as it stands today, given it was then introduced into the Diagnostic and Statistical Manual of Mental Disorders-III (DSM-III) in the 1980s (Oldham, 2004). Nonetheless, the notion of a ‘personality disorder’ was introduced to the DSM-III whilst it was still a contended diagnosis. The diagnostic approach was criticised as atheoretical by psychoanalytic scholars (Blatt & Levy, 1998) and many felt it was a controversial addition to the manual due to its confusing term (Merskey, 1980). Within the DSM-III, criteria were developed to distinguish personality disorders from that of mood disorders and schizophrenia. Notably, this diagnostic criteria is merely descriptive as it does not provide an account of a cause.

1.2.2 Diagnostic Criteria

Before defining the current concepts of personality disorder, it is important to highlight that, as seen above, this diagnosis was born from the medicalised model of psychiatry in which the diagnosis is a construct used to describe individuals who display certain symptomology. The personality disorder diagnosis is often viewed as controversial (Lewis & Grenyer, 2009), specifically by those who receive the diagnosis (Lester et al., 2020), with many rejecting the language and negative connotations surrounding it. With that being said, it is important not to diminish the views of those who find it helpful to receive the diagnosis (Horn et al., 2007). The diagnosis of a personality disorder is the term currently used within

NHS mental health services. This research will continue to use the term personality disorder throughout as it is focused on NHS systems, whilst simultaneously acknowledging how contended this diagnosis is.

Within current psychiatric diagnostic practice, a personality disorder is defined as “an enduring pattern of inner experience and behaviour that differs markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment” (DSM-5; American Psychiatric Association, 2013). Within the DSM-5, which is traditionally used in America, and International Classification of Diseases-11 (ICD-11; World Health Organization, 2018), which is traditionally used in UK and European countries, there are ten types of personality disorder which are clustered into three groups; Odd or eccentric; Dramatic, emotional or Erratic; Anxious and Fearful. This study is specifically concerned with borderline personality disorder (BPD) and emotionally unstable personality disorder (EUPD) which sit within the ‘Dramatic, Emotional or Erratic’ cluster.

Within psychiatry, BPD is viewed as a complex mental health condition whereby individuals have a long-term pattern of unstable interpersonal relationships, distorted sense of self and strong emotional reactions (DSM-5). It is characterised by self-harming behaviours and suicide risk, with approximately 10% of those diagnosed taking their own life (Paris, 2019). A marked characteristic of the diagnosis is emotion dysregulation which leads to difficulties when returning emotional arousal to a typical baseline (Snowdon & Kane, 2003). To receive a diagnosis of BPD individuals must meet five of the following criteria; frantic efforts to avoid abandonment, unstable or chaotic interpersonal relationships, disturbed sense of identity, impulsive or reckless behaviours, suicidality and/or self-harm, intense and uncontrollable emotional reactions, chronic feelings of emptiness, inappropriate or intense anger and paranoid ideation of dissociative symptoms (DSM-5). Of note is that the

International Classification of Diseases-10 (ICD-10) defined a disorder that is conceptually similar to BPD but termed it emotionally unstable personality disorder (EUPD) with two subtypes; borderline and impulsive. Therefore, dependent on which diagnostic manual is used when diagnosing, it may be called either BPD or EUPD. The two terms are used interchangeably in the literature but for the purpose of this study the term EUPD will be used hereafter, as the UK’s National Health Service adheres to the ICD manual.

EUPD is the most prevalent personality disorder in clinical settings (Ten Have et al., 2016). Lifetime prevalence rates of EUPD diagnoses were found to be between 5-6% of the American population (Grant et al., 2008) and 1.1% of the Dutch population (Ten Have et al., 2016). Studies exploring the prevalence rates in UK samples are scarce but Coid et al. (2006) found the rate to be 4% in a sample of 626 adults living in UK households. In the adolescent population it is harder to ascertain prevalence rates due to the debate of whether an adolescent should receive a diagnosis based on personality whilst they are still developing. Conversely, some clinicians believe that a diagnosis can be given based upon emerging symptoms in adolescence (Adshead et al., 2012). A Canadian study reported a steady increase of EUPD diagnoses within 14 to 17 year old girls between the years of 2000-2012 (Cailhol et al., 2017). Despite the above research, the construct of EUPD cannot be easily ‘measured’ and so prevalence rates needs to be considered tentatively, as it depends on who has been given a formal diagnosis and how this came to fruition. For example, a meta-analysis revealed that females account for 76% of individuals with an EUPD diagnosis when compared to males and this heavy skew is still prevalent today (Widiger & Trull, 1993; Becker, 2019). Recent research has highlighted the role of clinician bias (Woodward et al., 2009) and sampling bias (Bjorklund, 2006) when reporting increased diagnoses of EUPD in females, indicating that statistics may be conflated by these variables.

EUPD diagnoses also have the highest comorbidity rate of any other mental illness. At some point in their life, 75% of individuals with an EUPD diagnosis were found to meet criteria for mood and anxiety disorders (Grant et al., 2008) and 21% were found to have comorbid bipolar (Fornaro et al., 2016). This too is influenced by gender as males diagnosed with EUPD are at greater risk of comorbid substance misuse (Grant et al., 2008) and females diagnosed with EUPD are more likely to meet criteria for eating disorders (Gregory, 2006).

1.2.3 Theories of EUPD

Within westernised psychiatric and psychological accounts, there is no singular theory used to explain the cause of an EUPD diagnosis. As such, biological, attachment and psychosocial trauma theories are discussed below to provide a biopsychosocial view of the diagnosis. However, it is important to highlight how contended these theories are given that EUPD is a construct which cannot be measured. Furthermore, the theories of EUPD are posited on the aforementioned history of the diagnosis based on workings from nearly 100 years ago. Thus, the theories derived since its conception into the DSM-III have been applied to the preconceived set of criteria that was already established.

1.2.3.1 Biology. Whilst strongly contended, biological theories of personality have been widely researched. Hans Eysenck was a leading psychologist in this area, which led to the development of his three-factor model of personality (Corr et al., 2006). Eysenck believed all humans have extraversion, neuroticism and psychoticism but that the levels of these traits are mediated by individual limbic systems. In line with this biological view, many studies have tried to ascertain the heritability of EUPD. A systematic literature review by Amad et al. (2014) aimed to examine all existing literature on the genetics of EUPD and found an estimated heritability of approximately 40%. Twin studies reveal moderate levels of shared heritability for an EUPD diagnosis (Skodol et al., 2002) but this is complex given that twins are likely to be sharing the same environment, meaning a gene-environment interaction cannot be ruled out.

Brain alterations have also been investigated as a potential cause of EUPD. O'Neill and Frodl (2012) found significant reductions in the size of the orbitofrontal cortex and amygdala in individuals with an EUPD diagnosis, both of which are involved in the regulation of stress and emotion. Furthermore, Yang et al. (2016) found increased levels of gray matter in those diagnosed with EUPD. Additionally, the hippocampus has been found to be smaller for this group, which is commonly found in individuals with Post Traumatic Stress Disorder (PTSD) (Chapman & Gratz, 2007). This indicates a biology-environment interaction which is further evidenced by the fact that those with an EUPD diagnosis have a dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis (Grossman et al., 1997). The HPA axis is responsible for the production of the stress hormone cortisol and aims to keep homeostatic balance when under stress. A dysregulation of the HPA axis is commonly found in individuals exposed to adverse childhood experiences (ACEs), suggesting that biology may have an implication in EUPD development but that environmental factors are contributing to these differences.

1.2.3.2 Attachment. Research has investigated the link between attachment theory (Ainsworth & Bowlby, 1991) and EUPD development. Since its conception, attachment theory has been widely ascribed to in westernised cultures (Quinn & Mageo, 2013) but this too has been contested using feminist and ethnocentric critiques (Slater, 2007). Attachment theory highlights the importance of early caregiver bonds in the development of future interpersonal relationships. It posits that during childhood we develop internal working models which guide our sense of self and provide expectations of interpersonal relations (Johnson et al., 2007). If an infant's needs are not met during childhood they may construct an internal working model which views others as inaccessible and uncaring which is likely to activate during adult relationships (Levy et al., 2015). If we experience neglect or aggression from caregivers whom we try to form attachments with, we are more likely to develop an insecure attachment which leaves individuals with a compromised view of themselves and others (Critchfield et al., 2008). Similarly, this early maltreatment may leave children feeling confused and unsure of their approach to forming relationships. They may anticipate abuse and neglect whilst simultaneously desire protection and support from the people they are wary of. Furthermore, attachment theory demonstrates how parental invalidation may have significant impacts on children. When upset, children instinctively seek the support of caregivers to help soothe, regulate and contain their emotions. If parents are consistently invalidating with their responses and they dismiss, blame or are erratic in their approach then the child is left unsure of how to self soothe and may believe they are at fault (Hoermann et al., 2004). This can lead to emotion regulation difficulties when they are older, a characteristic symptom of EUPD. Moreover, the child may learn to ‘up-regulate’ or ‘down-regulate’ their emotions to receive an appropriate response by caregivers but this may also leave them feeling like their baseline emotions are invalid, creating a pattern of dysregulation (Linehan, 1993). Further linked to the importance of attachment theory is the Fonagy et al. (2000) view that EUPD is characterized by a reduced capacity to mentalise, especially about oneself. Fonagy et al. (2000) describe how in order to understand others, our needs as children and our mental states need to be understood by supportive caregivers. Thus, children who do not receive consistent emotional responses from caregivers, are frequently invalidated or may have suffered from abuse have less opportunities to facilitate mentalisation. The child may purposefully inhibit their ability to mentalise so that they do not have to think about other people’s wish to harm them. Furthermore, mentalization may not have been modelled by caregivers, meaning they are less aware of their own and others emotional states; a characteristic of EUPD symptomology. Overall, a rupture in attachment security is likely to evoke developmental trauma (Macintosh et al., 2015), a further characteristic typically seen in those with an EUPD diagnosis.

1.2.3.3 Psychodynamic. In a psychodynamic understanding of EUPD, the concept is understood developmentally, rather than diagnostically, as a way of characterising defensive responses to adversity in early caregiving (Gabbard, 2005). Key to the psychodynamic understanding of EUPD is object-relations theory. Object relations theorists stress the importance of early family interactions, particularly the mother-infant relationship, in personality development. It is believed that infants form mental representations of themselves in relation to others and these internal images significantly influence interpersonal relationships later in life (Mitchell, 1984). Thus, a psychodynamic view of EUPD development would consider the following four components: a biologically based temperament, a set of internalized object-relations, an enduring sense of self and a specific set of defence mechanisms that have been deployed in order to protect the individual (Gabbard, 2005). There have been some attempts to revise diagnostic criteria to take a more psychodynamic developmental account but with limited acceptance in mainstream psychiatry and psychology (Blatt & Levy, 1998). Also important within psychodynamic understandings of mental illness is the concept of containment, widely posited by Bion (1962). He described his view of the ‘container’ and ‘contained’, in which a mother typically receives the unwanted projections and emotions from the child and processes them in a way that can be returned to the infant in a form that can be taken in by the child. Finlay (2015) writes that a mother’s containing function helps the infant to develop self-regulation, eventually developing their capacity to self-contain. However, if an infant does not receive such containment from their mother, then they may struggle to regulate their emotions. By viewing EUPD diagnoses in this way, it can be said that this removes some element of stigmatisation and responsibility from the individual, as their behaviours make sense in the context of their developmental upbringing. Nonetheless, it is possible this moves the sense of ‘blame’ onto the parents of a child, with a tendency to underestimate the social determinants of emotional and relational distress (Smail, 2018). Overall, a psychodynamic account of the diagnosis recognises the importance of early developmental relations and the impact this has on trauma presentations.

1.2.3.4 Trauma. Trauma can be defined as “an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being” (Asmussen et al., 2022, p. 6). Common events leading to traumatic experiences can include, but are not limited to, child neglect, intimate partner violence and physical and sexual abuse (Gerber & Gerber, 2019). There appears to be an undeniable link between EUPD and trauma experiences. By linking the regulatory and relational difficulties associated with personality disorders, this offers a more developmental and relational understanding and is reflected in the proliferation of trauma informed services. Recently, Porter et al. (2020) conducted a meta-analysis of 97 studies comparing those with an EUPD diagnosis to a non-clinical population and found that individuals diagnosed with EUPD are 13 times more likely to report childhood and/or developmental trauma than their non-clinical counterparts. The most common form of trauma was physical neglect (48%), followed by emotional abuse (42%), physical abuse (36%), sexual abuse (32%) and emotional neglect (25%). Additionally, Geselowitz et al. (2021) found that ACEs during preschool were particularly significant in the early development of EUPD. Wolke et al. (2012) found that bullying is a strong predictor of EUPD development even when controlling for confounders. Those diagnosed with EUPD who had experienced bullying described feelings of loneliness, anger and loss of trust (Berger, 2007). A further study of 358 individuals diagnosed with EUPD found that 84% reported biparental abuse and/or neglect by the age of 18 and a high incidence of caregiver bereavement (Zanarini et al., 2000). Furthermore, the study found that emotional denial of ACEs by a caregiving figure was a predictive factor of EUPD development. This highlights how trauma alone may not directly cause the development of EUPD traits but the way in which the parent responds to the child. Horwitz et al. (2001) further confirmed this view and found that a parent’s response to abuse may be more significant than the abuse itself in determining future outcomes. Similarly, Bradley et al. (2005) found that a stable family environment lowered the risk of developing an EUPD diagnosis, compared to an unstable one which increased risk.

The role of ACEs and how they mediate temperament has been well explored within EUPD literature. It has been found that inappropriate anger, poor emotional control, impulsivity and aggression leads to a higher risk of developing an EUPD diagnosis when an adverse childhood trauma has also occurred (Bozzatello et al., 2019; Belsky et al., 2010). The founder of Dialectical Behaviour Therapy (DBT), Marsha Linehan, developed the Biosocial theory of EUPD which encompasses the notion of temperament interacting with environmental trauma. The Biosocial theory suggests EUPD is the result of a dysfunction in the emotional regulation system which mediates cognition, behaviour, interpersonal communication and self-identity (Linehan, 1993). It states that if an emotionally vulnerable child experiences invalidating environments at any stage in development, they are at risk of unpredictable emotional states. Linehan (1993) defines an invalidating environment as one in which communication of private experiences is met by erratic, inappropriate or extreme responses. This can then lead to both impulsive and self-injurious behaviour to regulate emotions (Marcovitz, 2009). Whilst the highest levels of validation and invalidation are provided by parents (Musser et al., 2018), an invalidating environment also comprises of school, peers and extended family accounting for a wider range of traumas. This highlights the complex interaction of predisposed biological temperament interacting with environment.

Particularly, the role of an invalidating environment which can feel highly pejorative and traumatic when it occurs over many years. An important distinction that needs to be considered is not the invalidation itself but rather an individual's emotional response to consistently feeling like their thoughts and emotions are unimportant or unworthy. Crowell et al. (2009) added to the Biosocial theory by proposing that impulsivity plays a key role in mediating the development of EUPD. Her work found that emotionally vulnerable children who had experienced invalidation were more likely to develop an EUPD diagnosis if they were also highly impulsive. Overall, the link between trauma experiences and an EUPD diagnosis has been for some an argument against the diagnosis and its use. These critiques will be outlined below.

1.2.4 – Diagnostic Critiques

The diagnosis of a personality disorder, namely EUPD, is a controversial diagnosis which brings with it a series of assumptions and stereotypes that ultimately impacts the individual displaying symptoms. The role of stigmatization, trauma and a feminist critique of the diagnosis will now be explored. Broadly, the following critiques question the positivist assumptions that underlie diagnostic categories of mental health conditions and the notion that disorders exist within an individual (Boyle & Johnstone, 2014).

1.2.4.1 Stigmatization. Within recent years, the debate regarding the purposefulness of diagnostic labels has grown in strength. This is partly due to people rejecting the notion that their illness can be categorized or internalized as something deficient within themselves (Perkins et al., 2018). With EUPD, to be told that your personality is disordered suggests that there is something fundamentally wrong with who you are; putting onus on the individual for their presentation. This then discredits the traumatic experiences that many people diagnosed with EUPD may have had. Berger (2014) stresses the importance of viewing the label of personality disorder within its context of predominant use in the western world. The prevailing discourse in the west is that of self-autonomy and goal directed behaviour. Thus, to achieve these autonomous goals individuals must be stable in their personality and identity. Any behaviour that deviates from stability, such as self-harm, suicidality and aggression is therefore seen as a deviation from societal norms and something that should be pathologized. Berger (2014, para. 9) reflects on how some forms of self-harm, such as over-working to the point of stress, lack of sleep and neglect of personal relationships are not pathologized in the same way as they resonate with the idea of achieving greater goals. She notes that "as self-injury cannot be reconciled with other cultural norms, self-injury is seen as a manifestation of severe pathology; the person must be viewed as disordered for such an action to make sense". In psychoanalytic terms, this concept could be seen to align with the defence of 'projection', whereby one projects their own unwanted feelings and urges into another. In this example, it may be easier for individuals who engage in forms of self-harm that are seen as 'socially acceptable' to project their 'negative' feelings into those who self-harm via injury, rather than recognise these behaviours in themselves.

Furthermore, as EUPD is inextricably linked to high risk behaviours such as self-injury and suicidality as well as emotional dysregulation and difficulties forming healthy relationships, mental health staff working with this client group have been found to feel helpless and simultaneously 'burnt out' from working with high levels of self-injury and suicide (Nehls, 1992). The levels of burnout was found to be four times greater than that of staff working with individuals with schizophrenia and bipolar (Nehls, 1992). Further research has found that the high dropout rate from therapy for service users with an EUPD diagnosis leaves staff feeling infuriated and split from other multidisciplinary team members (Cleary et al., 2002). High levels of burnout can lead to a lack of empathy from staff, with many studies finding that clients diagnosed with EUPD are often called manipulative, attention-seeking and disruptive (Bodner et al., 2011). The stereotypical views of those with an EUPD diagnosis seem to have become so entrenched in mental health services that some staff may automatically associate the diagnosis of EUPD with these terms, purely because that is what they expect the service user to be like. Additionally, EUPD is viewed by some as a non-genuine illness due to the lack of biological causes that underpin it (Kendell, 2002). This would appear problematic in modern day psychiatry which follows a biological pathway of medication and can explain some of the stigmatization that may be seen in services. At the same time, some staff view individuals with an EUPD diagnosis as “in control of their behaviour…therefore manipulative and dangerous” (Weight & Kendal, 2013, p. 3). It is noteworthy how this statement places the responsibility of the illness onto the individual. Work by Bodner et al. (2011) found that stigmatization levels were greatest in psychiatrists and lowest in psychologists when compared to nurses, whose scores sat in between. Psychiatrists had greater levels of antagonistic judgements but all three staff groups reported a desire for increased education about the diagnosis. The stigmatization associated with EUPD is also felt by the individuals living with the diagnosis. It has been found that they felt health care professionals had a poor understanding of the diagnosis and they were often deemed as untreatable (Leliott, 2002). They also believed they were blamed for their diagnosis and were considered not to be mentally ill.

The Power Threat Meaning Framework (PTMF; Johnstone & Boyle, 2018) is an alternative to mental health diagnoses which has gained interest in psychology and psychiatry over the past five years. The PTMF suggests that a non-diagnostic approach to mental health in which we understand how people’s difficulties are because of the meanings they have attributed to the power and threats they have experienced over their lifetime is required. This would then create more hopeful narratives for individuals who are facing adverse difficulties, rather than seeing themselves as mentally ill. Similarly, the movement ‘A Disorder for Everyone’ (AD4E) has been co-produced by a co-author of the PTMF and it has gained notoriety since its conception in 2016. AD4E advocates for ‘dropping the diagnosis’ to challenge the culture of psychiatry. By seeing people’s pain as a result of their experiences, rather than a malfunction of who they are, this would re-author the dominant discourses which they hold about themselves. Simultaneously, it is important not to ignore the views of individuals who wish to receive a diagnosis of EUPD as it helps to affirm and define the difficulties they may have experienced over many years. In an effort to contend the terminology so as to not stigmatise individuals, it is possible that services then underestimate and minimise the relational emotional distress that many people may have experienced in earlier life. Thus, holding the two alternative views together allows individuals to decide how they wish to frame their own narrative.

1.2.4.2 Feminist Perspective. Before entering into feminist critiques of EUPD, it is pertinent to discuss the treatment of women’s mental health throughout history. First beginning in ancient Greek mythology, we have long been taught about women who struggled to control their emotions, such as Medusa and Pandora (Ducsay, 2015). By the 18th century, Greek physician Hippocrates wrote about a woman’s uterus being a problematic organ which floated around the body, causing havoc to the brain (Taylor, 2022). He termed this illness ‘hysteria’, which he attributed to a woman’s body being physiologically cold and wet, hence prone to sickness (Sigerist, 1987). Symptoms included anxiety, a sense of suffocation, tremors and convulsions; otherwise known as madness (Ussher, 2013). The ‘treatment’ for hysteria varied from sexual activity to sexual abstinence, fumigation of the genitals and childbirth, in a hope this would ‘push’ the uterus back into its designated place within the body (Tasca et al., 2012).

It was within the 20th century that hysteria was considered a mental illness, with notable psychoanalysts such as Freud and Charcot dedicating their research to its cause (North, 2015). They transpired that hysteria was the result of sexual trauma in a woman’s past, leading to Freud's widely published work on Seduction and Oedipal theory. This further fuelled the belief that hysteria was a legitimate diagnosis, resulting in its addition to the DSM-II. Hysteria was only removed from the DSM-III in 1980 due to the rise in diagnoses such as anxiety and depression in women, which were felt to replace it (North, 2015).

Aside from hysteria, throughout history women have also been accused of witchcraft. In the 1650s certain religious churches, particularly in England, allowed females to become spiritual leaders, no longer a role that could only be occupied by men. However, some English Protestants vehemently disagreed with this decision and deemed female spiritual leaders to be witches who needed exterminating (Rosen, 2017). It was thought that "witches were usually women, for it was believed that being the weaker sex, women found it harder to resist the temptations of the Devil and his demons" (Ducsay, 2015, p. 4). Thus, predominantly at the hands of men, witch hunts begun and women were burned at the stake, killed and tortured without any evidence of such 'witchcraft' occurring (Cline, 2018).

Connecting these narratives to what we see in present day, Ussher (2013) writes how the symptomology and treatment of women receiving a diagnosis of EUPD is concerningly similar to those who received a diagnosis of hysteria. However, EUPD also incorporates more masculine characteristics, such as inappropriate anger, into its diagnostic criteria. Thus, Jimenez (1997) writes that a woman diagnosed with EUPD is seen as demanding and angry and labelled mentally disordered for behaving in a way that is acceptable for a man. In her writings, Taylor (2022, p. 71) summarises the work of Ussher (2013) who states that "the same women who were once burned at the stake for being witches then became the women who were diagnosed as hysterical and locked away in asylums and are now the women being diagnosed with EUPD and medicated for the rest of their lives". As such, it can be said that perhaps modern day psychiatry is not as far removed from the abhorrent treatment of women in history as one may like to think.

A further feminist critique of the EUPD diagnosis is underpinned by the notion that it pathologizes women’s emotions, in particular their emotions to abuse and oppression (Veysey, 2014). Aves (2020, para. 30) outlines a feminist perspective on diagnostic labels and mental illness which views it as a concept to “name the powerless as mad, thus removing their credibility and ability to speak out about their oppression and trauma” in a patriarchal society. Capes-Ivy (2010) wrote about her experiences of living with EUPD and how she came to a realisation about the stereotypes placed on females. She firstly notes that the characteristic symptoms of EUPD are what is stereotypically feminine behaviour (mood swings, anxiety, irritability) but to a heightened level. Yet, when these heightened emotions are displayed, they are defined as abnormal in order for them to be ‘treated’. Secondly, that the symptoms of EUPD are more lenient to a male orientated world than a female one. For example, if a female expresses ‘inappropriate anger’ she would be acting unfeminine; yet fighting and aggression are often normalised in male culture. Similarly, engaging in risk taking behaviours, such as inappropriate sexual relationships, would be characteristically unfeminine but may be seen as a norm for men.

Additionally, Shaw and Proctor (2005, p. 485) discuss a diagnosis of EUPD as a being a form of social control. They speak of the dual approach to the diagnosis; that “EUPD can be applied to women who fail to live up to their gender role because they express anger and aggression” and that “the diagnosis is also given to women who conform too strongly, by internalizing anger and expressing this through self-injury”. This creates a double bind of placing women whose behaviours are seen as unfeminine into the role of an overemotional female. Aves (2020) addresses the view that EUPD is just another way to explain the behaviour of women without recognising the impact that gender, power and history has played in creating societal norms. She states that it is a social construct which pathologizes normal reactions to trauma in order to be able to treat it until it conforms. Ave’s (2020, para.

34) discusses how treatment for EUPD may exist “only to contain women’s distress so that other people do not have to witness or acknowledge its source”.

1.2.4.3 Complex Trauma Diagnosis. As aforementioned, one reason the personality disorder diagnosis is contended in mental health settings is its inherent links to trauma. Trauma-informed approaches acknowledge the need for organisations to grasp a complete picture of an individual’s life rather than viewing them as a product of their illness. A trauma informed approach to EUPD would recognise that trauma survivors have gained actions and behaviours to act as protective mechanisms for coping, even though they may be seen as maladaptive by others (Brickel, 2019). Individuals diagnosed with EUPD are simply doing what they can to survive in the only way they have been shown how. Brickel (2019) recognises that many individuals living with EUPD may have insecure or disorganised attachments and believes that viewing EUPD through this lens would help professionals to empathise with their clients rather than viewing them as ‘wrong’ in some way. Thus, there is advocation to change the term EUPD to that of ‘Complex Post Traumatic Stress Disorder’ (C-PTSD) or ‘Complex Trauma’ (CT) as it highlights the emotional trauma that many with the diagnosis have experienced and would hopefully reduce the level of stigmatisation they receive (Kulkarni, 2017). It is argued that the significant symptom overlap with other disorders such as PTSD means that it should not stand alone as a disorder of personality, instead it should recognise the traumatic experiences that individuals have faced (Pagura et al., 2010). A study by Quadrio (2005) found that clinicians had significantly fewer negative connotations about individuals diagnosed with PTSD and were more likely to view them as victims of traumatic events, rather than classify them as people with disordered personalities. Despite the links to trauma, the complexity of changing the diagnostic term to one which encompasses a trauma-informed lens is discussed by Zlotnick et al. (2003). They reflect on how PTSD is an Axis 1 disorder in the DSM-5 which signifies a short-term duration whereas

EUPD is an Axis 2 disorder which means it will have a longer-term impact. Despite this, their research has identified the comorbidity rate of PTSD and EUPD to be up to 76%, highlighting a need for these two presentations to potentially be viewed harmoniously, rather than as distinct categories.

1.2.5 – Treatment Guidelines

Recommended treatment guidelines for EUPD in the UK are provided by the National Institute for Health and Care Excellence (NICE). Currently, there is no prescribed medication that should be offered for the sole treatment of EUPD symptoms including self-harm, risk taking behaviour and emotional instability (NICE, 2009). Concerningly, Paton et al. (2015) surveyed 2,600 individuals with an EUPD diagnosis in the UK and found that 92% were prescribed psychotropic medication, mainly an antidepressant or antipsychotic for the symptoms of EUPD, not for a comorbid illness. This indicates that the use of psychotropic medication for EUPD in the UK is largely outside the licensed recommendations by NICE. However, the guidelines are 13 years old at present meaning new forms of pharmacology may have emerged since.

Psychological treatment is the recommended action for individuals with an EUPD diagnosis (NICE, 2009). The current gold standard treatment recommended by NICE in the UK is Dialectical Behaviour Therapy (DBT). DBT is an evidence-based treatment to help those with EUPD reduce self-harming behaviours and suicidality (Linehan, 1993). As stated by NICE, it is an intensive treatment that focuses on enhancing a person's skills in regulating their emotions and behaviour. The therapy can help a person gain control of behaviour such as self-harm and substance misuse. DBT usually takes place over one year with weekly one-to-one and group meetings. It is offered on the NHS for both adults and adolescents with self-harm and suicidal behaviours. It can be provided by individual practitioners who have completed DBT training or it can be provided by specialist DBT services which only delivers this form of therapy. However, dependent on NHS commissioning not all trusts in the UK will have a sole DBT service meaning it may be harder to access dependent on where you live. Within adolescent DBT services, parents/carers are encouraged to attend the weekly group meetings to learn the skills alongside their child. This demonstrates how the model integrates attachment and relational theories into its approach. Given the strong research link between EUPD development and parenting, particularly that of motherhood, it is important that the needs of mothers who have an EUPD diagnosis is further explored.

1.3 - Perinatal Mental Health

1.3.1 Definition and Overview

As mentioned above, developmental trauma experiences which often occur in childhood can have important implications for those who receive an EUPD diagnosis. Thus, the next half of this chapter will now explore perinatal mental health services and how they are designed to work with mothers who have an EUPD diagnosis.

The perinatal period spans from conception of a child to 12 months after their birth (NHS England, 2018). Approximately 20% of women will experience a mental health difficulty in the perinatal period (Russell et al., 2017) and 84% of women will experience ‘baby blues’ after birth, signified by low mood for two weeks (O’Hara & Wisner, 2014). It is further estimated that 10% of women will experience a mental health difficulty that requires clinical services (Hogg, 2013). Within the UK, perinatal mental health support is provided by the NHS. NHS England’s (2017) Five-year Forward together with the NHS Long Term Plan (NHS England, 2019) aimed to transform and create new specialist perinatal services in England. Perinatal intervention is designed to have positive outcomes for both mother and infant, which is pertinent given the association between perinatal mental health difficulties in mothers and the increased likelihood of emotional and behavioural problems in their infants

(Huntley et al., 2017). In 2010, fewer than 15% of NHS trusts had specialist perinatal services available and more than 40% of trusts provided no service at all. It was estimated that for every one year cohort of births in England, the long term costs from lack of timely access to perinatal mental health care was £1.2 billion to the NHS (NHS England, 2019). Additionally, the 'Mothers and Babies: Reducing Risk through Audits and Confidential Enquires Across the UK' organisation (MBRRACE-UK) found that black mothers were almost five times more likely to die from pregnancy and childbirth related causes and Asian women were nearly twice as likely (Draper et al., 2017). Thus, the need to increase access to perinatal services in England was partly driven by the MBRRACE report outlining the concerning statistics surrounding maternal deaths and mental health. Currently, all 44 NHS trusts in England now provide specialist perinatal mental health support due to the increase in investment. By 2023/24, 66,000 women with moderate to severe perinatal mental health difficulties must be able to access care and support in the community (NHS England, 2019).

According to national perinatal service specification, a perinatal problem is one that occurs for the first time during pregnancy and 12 months postnatally or a pre-existing condition that may relapse or recur in pregnancy or the postpartum year (Royal College of Psychiatrists; RCPsych, 2018). Mothers with an EUPD diagnosis would likely fall into the latter category, as their difficulties would likely exist before pregnancy. Due to the Long Term Plan, perinatal support is increasing from 12 to 24 months after birth. There will also be increased access to psychological therapies for women as well as mental health checks for the partners of those accessing specialist perinatal mental health support (NHS England, 2019).

It is important to note the distinction between perinatal mental health services and parent-infant mental health services (PIMHS), both of which are provided by NHS England. The Long Term Plan set out a vision for "a comprehensive offer for 0-25 year olds that reaches across mental health services for children, young people and adults" (NHS England, 2019,

p. 51). As a result, certain NHS trusts received some funding to implement PIMHS services. These services support families where there are concerns about the parent-infant relationship from conception to age two. By targeting the relationship between infant and parent it aims to enhance the mental and physical health of the baby as well as its future development (Olander et al., 2021). Thus, whereas PIMHS services work with both parent and infant, perinatal services focus on the mother’s mental health. Furthermore, PIMHS services typically do not exclude parents based on any mental health diagnoses, with parents not requiring a mental health diagnosis to be able to access the service. This stands in contrast to perinatal services whereby a diagnosable mental health problem needs to be present in order to access the service.

1.3.2 The Perinatal Mental Health Pathways

To implement the Five Year Forward and Long Term Plan, £356 million was invested into specialist perinatal mental health services from 2015 to 2021. As part of the transformation, NHS England created the Perinatal Mental Health Pathways (NHS England, 2018). The Perinatal Mental Health Pathways were developed in collaboration with NICE and the National Collaborating Centre for Mental Health. Experts by experience, carers, practitioners, commissioners and academics were also involved in the creation of the pathways to ensure they were service-user led and co-produced with the people who will need them the most. A specialist perinatal mental health service (PMH) is defined as a specialist community perinatal mental health team and/or inpatient mother and baby units (MBUs). The community teams offer specialist psychiatric and psychological assessments for women with complex or severe mental health problems. A MBU provides inpatient care for women with severe mental health difficulties during the last trimester of pregnancy and the first 12 months after childbirth. The Perinatal Mental Health Pathways has five routes, which are as follows:

Pathway One: Preconception advice – All women with a current or past complex mental health problem who are planning a pregnancy should receive timely preconception advice from a specialist PMH service before becoming pregnant. Up to 90% of women will cease taking their prescribed medication for a mental health difficulty when they become pregnant which can have adverse consequences on their mental health (NHS England, 2018).

Pathway Two: Specialist assessment – Women referred to a specialist PMH team with a perinatal mental health problem (known or suspected) should have timely access to a biopsychosocial assessment. This is to help reduce the risk of an undiagnosed mental health difficultly getting missed and to simultaneously improve identification rates so that a care plan can be put into place. If the care plan identifies a need for psychological intervention, this should begin in a timely manner using a treatment which emphasises a recovery-based approach.

Pathway Three: Emergency Assessment – On receiving a referral for a perinatal mental health crisis, the specialist PMH service should contact the most appropriate person (the woman herself, a family member, healthcare professional and so forth) without delay and agree the next steps. Once the biopsychosocial assessment has been conducted, the referral to a mother and baby unit must have started (if required) or intensive follow up care at home or by the specialist community team must have been agreed. The emergency assessment can be conducted by a secondary mental health team, such as a crisis resolution or liaison team, but it should be led by the specialist perinatal service where possible.

Pathway Four: Psychological Interventions – Women with a known or suspected mental health problem who are referred to the specialist perinatal mental health service should receive timely access to evidence-based NICE recommended psychological interventions.

The intervention can also be conducted via primary, secondary or tertiary care dependent on the woman's needs.

Pathway Five: Inpatient Care – Women who need unplanned inpatient care should have urgent access to an MBU. Due to the investment into perinatal mental health support, four new MBUs were established in England, taking the country wide total to 19.

The Pathway report acknowledges the need for specialist perinatal services to work with the wider system of care which may be involved with the woman and their family. However, it is dependent on local authority commissioning to decide how these partners work together with the service. Wider services include primary care, midwifery and health visiting. It also includes Improving Access to Psychological Therapies Services (IAPT) which treat individuals experiencing depression and anxiety disorders. This can involve treatment in the perinatal period but IAPT may refuse to take a case if it is considered to be above their threshold of risk. A wider service can also include community mental health services which women with a perinatal mental health need may already be accessing if they have a prior mental health difficulty (RCPsych, 2018). This may cause tension when deciding upon whom the lead service is for the woman with a perinatal mental health need. A different stance will be taken dependent upon the structure local perinatal services and their specific criteria.

Furthermore, as referenced above, mothers with an EUPD diagnosis would likely fall into the 'pre-existing' mental health category of perinatal criteria as their difficulties are likely to originate prior to pregnancy, but may become exacerbated by the perinatal period. Based upon the policy guidance, perinatal services should give equal importance to 'pre-existing' and 'new' perinatal conditions. However, from reading policy frameworks it seems pre-existing conditions are not given as much consideration. This leaves a somewhat 'grey' area of need which is open to interpretation by specific perinatal teams. New Maternal Mental

Health Services (MMHS) are currently being implemented in England to provide services to women who do not meet current perinatal criteria but this is focused on perinatal loss, birth trauma and parent-infant separation due to safeguarding concerns (Easter et al., 2022). Whilst this is a promising development, it seems the ‘grey’ area of pre-existing conditions such as EUPD still exists.

1.3.3 – EUPD and Motherhood

As discussed earlier, EUPD has been described as a disorder of attachment (Fonagy et al., 2000). Thus, it is understandable that current research places prominence on investigating the attachment security of the offspring of mothers diagnosed with EUPD (Argent et al., 2020). Macfie and Swann (2009) asked 30 preschool and early school age children aged 4 to 7 to undertake two story completion tasks which elicit responses arising from stressful interpersonal situations. The children of mothers diagnosed with EUPD were found to have significantly greater fears of abandonment, greater negative parent-child relationship expectations and higher levels of role reversal than controls. Additionally, they were more likely to verbalise shameful self-representations. Furthermore, 80% of 13-month old children who underwent the Strange situation (Ainsworth & Bell, 1970) displayed a disorganised attachment style, characterised by both avoidant and resistant behaviours towards their mother diagnosed with EUPD (Hobson et al., 2009). Similar findings have been found in research investigating attachment security in older aged children (Abela et al., 1995). In their study of 6 to 14 year old children whose mothers either had comorbid EUPD and depression diagnoses or depression alone, the children whose mothers had the comorbid diagnoses were more likely to display an insecure attachment style, excessive reassurance seeking and self-criticism, even when controlling for the mother’s concurrent depressive symptoms. Additionally, children aged 11 to 18 whose mothers have a diagnosis of EUPD exhibit increased difficulties with attention, delinquency and aggression as well as significantly lower self-esteem in comparison to controls (Barnow, 2006).

Research investigating the experiences of mothers diagnosed with EUPD are “disturbingly scarce given that many mothers are attempting to parent in the context of serious psychopathology” (Stepp et al., 2012, p. 1). Given the diagnostic critiques above, it is important to note the pejorative language used within this quotation whilst also recognising it conveys an important message about the lack of research in this area. Research has shown that many adults diagnosed with EUPD recall early life experiences characterised by rejection, devaluation, inappropriate instructions and insecurity (Zanarini et al., 1989) meaning the emotions that are inextricably linked with these early events may resurface or increase when they find themselves childbearing (Newman & Stevenson, 2005). This concept aligns itself to the term ‘ghosts in the nursery’ (Fraiberg et al., 1975) which posits that many parents who experienced ACEs may be haunted by unresolved issues from their past, which can unconsciously influence the way they think and behave towards their children. It has been found that mothers diagnosed with EUPD have difficulties in perceiving and reacting to their own emotional needs (Newman et al., 2007) and they have higher levels of post-natal depression than controls (Feldman et al., 1995). Current research continues to highlight the difficulties mothers diagnosed with EUPD face, including that they are likely to misuse drugs and alcohol during pregnancy (White et al., 2011) and postnatally (Feldman et al., 1995). Furthermore, mothers diagnosed with EUPD are more likely than control groups to be parenting without the support of a partner (White et al., 2011) and are more likely to report parenting stress, lower competence levels and lower satisfaction with being a parent than controls (Crittenden & Newman, 2010). As a result of these findings, it is unsurprising that parents with diagnosed EUPD can be considered to be ‘high risk parents’ who are likely to have attachment difficulties with their children and are likely to be overrepresented in child protection services (Newman & Stevenson, 2005).

1.3.4 – EUPD and the Perinatal Period

Given the research presented above and the multitude of studies investigating the offspring of mothers who are diagnosed with EUPD, research investing perinatal experiences for mothers diagnosed with EUPD is crucial for both the mother and child. To the best of the authors knowledge, only one study has investigated the experiences of mothers with an EUPD diagnosis during the perinatal period in the UK. Zacharia et al. (2020) interviewed 12 women with a diagnosis of EUPD who received perinatal mental health support in England. Using thematic analysis, key themes were identified: the women feeling judged to be unfit mothers, not feeling heard or understood by services, feeling that services struggled with their complexity of their needs, valuing specialist support to cope with their struggles in motherhood and valuing professional relationships that resembled real-life friendships. Their findings suggest that although this client group struggle to access the service provision they require, they place great importance on the help and support that they do receive. The results raise questions about how perinatal services can provide optimum support to this group of women.

Although not EUPD specific, Steele (2018) qualitatively investigated perinatal staff experiences of working within a perinatal service and identified six main themes. This included a misalignment between mothers' needs and service provision, awareness of the remits of specialist perinatal service provision and the importance of viewing mothers holistically. Whilst this research provides promising insights into staff views of working in perinatal services, it does not focus on staff who work with mothers with a diagnosis of EUPD. Furthermore, to the author's knowledge this is the only study that has investigated perinatal staff views in the United Kingdom (UK), highlighting that there is a scarcity of research exploring the views of staff who work in specialist perinatal mental health teams.

1.4 Rationale For the Current Study

The above research has provided evidence that mothers diagnosed with EUPD will be at greater risk of perinatal difficulties, that their children may be at risk of greater mental health difficulties and that women with a diagnosis of EUPD feel their needs are not met in the perinatal period. Currently, the experiences of perinatal mental health staff working with mothers diagnosed with EUPD is unknown and it is also unknown how perinatal staff perceive the support offered by perinatal services in the context of supporting mothers with this diagnosis.

Therefore, the current study aims to examine perinatal mental health staff experiences of working effectively with mothers who are described as having a personality disorder within the National Health Service. Effective care was operationalised in the current study using the principles of the Care Quality Commission’s (CQC) and World health Organisation’s (WHO) definitions of effective care. They respectively define effective health care as “we mean that peoples care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the available evidence” (CQC, 2022, para. 1) and “providing evidence-based healthcare services to those who need them” (WHO, 2020, para. 1). Namely, it was operationalised as any care which leads to beneficial outcomes for service users and anything which improves the therapeutic relationship between staff and service user. This research will bridge the gap between existing research which highlights the difficulties this client group experience in the perinatal period with novel research hoping to highlight frontline experiences of how best to work with mothers who have a diagnosis of EUPD, so that services are better able to support them. As such, it will be providing an original contribution to the knowledge base. This study is timely considering the NHS Long Term Plan aims to improve access to evidence-based treatment for women with a personality disorder diagnosis in the perinatal period (Alderwick & Dixon, 2019).

The findings of this research could provide evidence to NHS commissioning documentation on how best to develop and adapt perinatal services as they continue to expand in the UK. By doing so, this would benefit individuals who are diagnosed with EUPD who access perinatal services. Furthermore, it would highlight areas of service that are working well or could be improved for the staff members, helping to reduce the high levels of burnout they can experience when working with this client group (Bland & Rossen, 2005). The aims of the current study are:

1. To explore themes in how perinatal mental health staff work effectively with mothers who have an EUPD diagnosis
2. To explore perinatal staff views of the adequacy of perinatal service provision for mothers diagnosed with EUPD

The rationale for the current study has been provided prior to conducting a literature review due to the lack of evidence surrounding perinatal mental health staff and their experiences of working with clients diagnosed with EUPD. This meant an insufficient number of studies were available to conduct a review of this topic. Nonetheless, the below literature review will now explore, more broadly, mental health nurses’ experiences of working effectively with clients diagnosed with EUPD. The results of this review will be used to inform the design and interview schedule of the current research.

1.5 Literature Review

1.5.1 Introduction

Given the research that has been presented above, particularly that of staff stigmatisation towards individuals with an EUPD diagnosis, it is unsurprising that much of the research looking at staff attitudes towards individuals diagnosed with EUPD has found negative associations of how they respond and interact with these clients. For example, an Australian study of 229 mental health practitioners found that 85% of them thought individuals with an EUPD diagnosis are ‘difficult’ to work with and harder to respond to than other client groups (Cleary et al., 2002). This was mirrored in the early work of Gallop et al. (1989) who found that diagnostic labels impact mental health nurses’ perceptions of service users. When reading hypothetical scenarios about a person diagnosed with schizophrenia and a person diagnosed with EUPD, the nurses responded more empathetically to the clients with schizophrenia and were more likely to offer belittling responses to the EUPD scenario. The authors concluded that this would lead to a lack of empathetic care.

Whilst these studies and those alike help to highlight the prejudicial care that is given to those with an EUPD diagnosis, research which aims to explore effective care that is given by staff working with individuals with an EUPD diagnosis is lacking. For the purpose of this review, effective care was operationalised using the definitions provided by the CQC and WHO, as referenced above.

Therefore, this systematic literature review aims to review the current literature exploring mental health nurses’ experiences of effective practice when working with individuals diagnosed with EUPD. Currently, no systematic literature review has reviewed the effective practices self-reported by nurses. The research question was:

1. What are the self-reported experiences which mental health nurses feel improve effective care for individuals diagnosed with EUPD?

1.5.2 - Method

Preferred Reporting Items for Systematic Reviews and Meta Analyses (PRISMA) guidelines (Moher et al., 2009) were used for this review. PROSPERO: International Prospective Register of Systematic Reviews were searched to confirm that previous reviews had not addressed the research question.

1.5.2.1 Search Strategy. Four electronic databases were searched in May 2022: Medline, CINAHL Complete, APA PsychArticles and APAPsychInfo. Search terms were kept broad and general so as to not discard any articles which may have been relevant at this stage (Table 1).

Table 1

Electronic Database Search Terms

Search No.	Search Terms	Results
1	"Personality Disorder*" OR "Borderline Personality Disorder*" OR "BPD" OR "Emotionally Unstable Personality Disorder*" OR "EUPD"	131,281
2	"Mental Health Nurs*" OR "Psychiatric Nurs*" OR "Nurse Practitioner*" OR "Nurs*"	160,896
3	"Therapeutic" OR "Relationship*" OR "Rapport" OR "Experience*" OR "Effective" OR "Practice*"	59,986
4	S1 AND S2 AND S3	95

1.5.2.2 Inclusion and Exclusion Criteria. Studies were included in the review if:

a) Qualitative Methodology. This was felt to be the best method to obtain first-hand experiences given by staff members, which quantitative methodology may not have captured
b) Participants had a nursing role, within any mental health setting
c) Aimed to explore effective practices, including the therapeutic relationship, when working with individuals diagnosed with EUPD

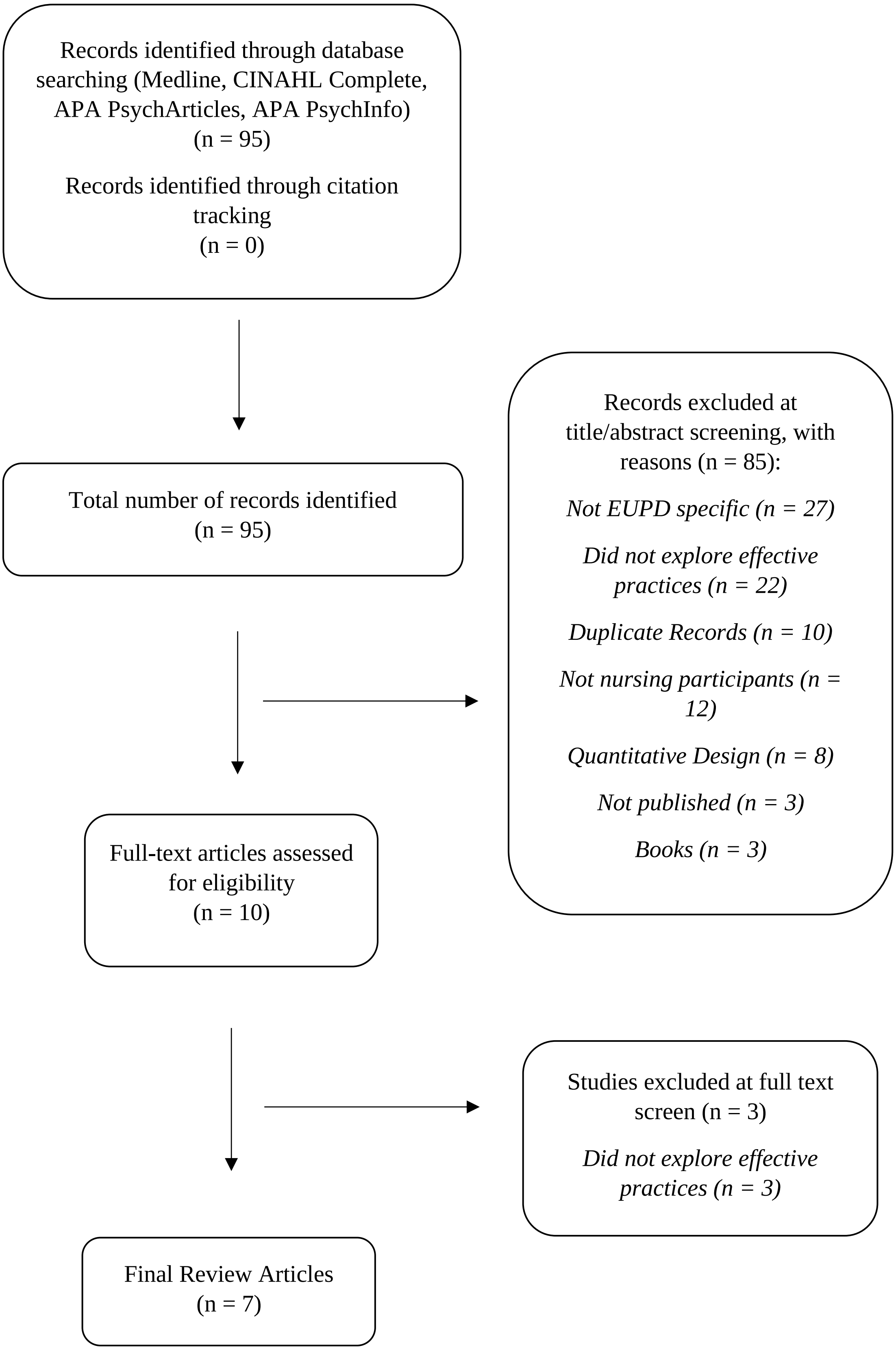
Studies were excluded if:

a) Quantitative Methodology
b) Did not aim to explore elements of effective care and/or the therapeutic relationship between staff and service user
c) Focused on personality disorders other than EUPD/BPD
d) Was not a peer-reviewed published piece of research

1.5.2.3 Screening Procedure. Ninety-five studies were produced from the electronic database search. Alongside this search, backwards and forwards citation tracking was used on the known articles to identify any studies which may have been missed. No further articles were produced. Grey literature was searched using Opengrey, Clinicaltrials.gov and Mednar to ensure relevant literature was not excluded from the review but no relevant articles were found. Title and abstract screening of the relevant articles was then conducted by the researcher against the inclusion and exclusion criteria of this review. Eighty-five studies were removed for lack of appropriateness (reasons can be seen in Figure 1 below) leaving 10 articles for full text review. From this, three articles were removed due to not focusing on effective practices, leaving seven full text articles suitable for the review. The full process can be seen using the PRISMA diagram (Moher et al., 2009) in Figure 1.

Figure 1

PRISMA Diagram of Search



1.5.2.4 Quality Assessment. The critical appraisal of research studies included in a systematic literature review is imperative when considering the appropriateness of a study design to help answer the research question (Young & Solomon, 2009). Critically appraising research ensures that best practice within the healthcare sector is grounded in the finest evidence (Long & Godfrey, 2004). Scientific literature within healthcare is ever increasing, meaning that critical appraisal is key to help distinguish between useful and flawed studies (Umesh et al., 2016). Umesh et al. (2016) discusses the rise of qualitative methodologies in healthcare literature, meaning critical appraisal tools focused on quantitative appraisal is no longer applicable. They argue that a tool specifically designed to appraise qualitative research is necessary.

Hence, for the quality appraisal of studies included in this literature review the Critical Appraisal Skills Programme qualitative research tool (CASP, 2018) was used. The CASP tool uses three areas of questioning; are the study results valid, what are the results and will the results help locally. The tool is efficient in its design and asks thorough questions. However, no scoring system is put in place meaning the authors discretion is required.

The rigour of all studies included in this review was high. All studies clearly stated their aims and justified their qualitative methodology well. Furthermore, the research designs were appropriate and explanations of their recruitment techniques were clearly indicated. All studies included details of ethical considerations and data analysis procedures. However, all but one study (Ratcliffe & Stenfert-Kroese, 2021) failed to note a researcher-participant relationship or include any reflexivity in their article. The discussion sections of each paper tended to be short in length but all studies gave clear statements of their findings. Four articles discussed areas for future research as well as highlighting some limitations of their work (Acford & Davies, 2019; Ma et al., 2009; Ratcliffe & Stenfert-Kroese, 2021; Stroud &

Parsons, 2013), with the remainder of the articles discussing implications of their findings only. Full details can be seen in Table 2.

Table 2

Quality Assessment of Included Studies

Author	Clear Statement of Aims	Qualitative Methodology Appropriate	Research Design Appropriate	Recruitment Strategy Appropriate	Data Collection Appropriate	Researcher-Participant Relationship Considered	Ethical Issues Considered	Rigorous Data Analysis	Clear Statement of Findings	Value of the Research
Langley & Klopper (2005)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Discussion of Implications and Generalisability
Acford & Davies (2019)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Discussed Future Research & Relevance to Clinical Practice
O’Connell & Dowling (2013)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Discusses Implications
Bowen (2013)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Discusses Implications

Ma et al (2009)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Discussed Future Research & Implications
Ratcliffe & Stenfert-Kroese (2021)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Discussed Future Research & Implications
Stroud & Parsons (2013)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Discussed Future Research & Implications

1.5.2.5 Data Synthesis. The systematic review followed a thematic synthesis framework (Thomas & Harden, 2008). The process was developed to help synthesise and integrate the findings of multiple qualitative studies. Thematic synthesis involves three steps, all of which were completed by hand by the researcher. The first is line-by-line coding of text which involves extracting all text labelled as ‘results’ or ‘findings’ in the original studies, including participants’ verbatim quotations. Each included article was read twice by the researcher, in order to improve familiarity with the data set. The process then progresses to stage two which follows that of thematic analysis whereby codes are generated into descriptive themes. Stage three of thematic synthesis is the development of analytical themes which incorporates descriptive themes to go beyond that of the original data to determine the key messages. By doing so, this helps to answer the aims of the systematic literature review.

1.5.3 Results

The researcher extracted study characteristics using pre-defined categories (Table 3).

Table 3

Study Characteristics of Included Papers

Author	Country	Sample Size	Service	Data Collection	Method of Analysis	Themes
Langley & Klopper (2005)	South Africa	10	Community Mental Health	Focus Group	Content Analysis	Trust: A foundation, Hook or Anchor; Knowing the Client; Takes time, Start Slowly; Available & Accessible; Honesty; Hope; Reality of the Patient’s Experience
Acford & Davies (2019)	United Kingdom	19	Acute Inpatient	Focus Group	Thematic Analysis	The Right Frame of Mind; Knowing the Service User; Knowing When to Engage; Service User Input; A Unified Approach; Structured Admissions
O’Connell & Dowling (2013)	Ireland	15	Community Mental Health	Interviews	Thematic Analysis	Borderline Personality Disorder: A Mixed Bag; Positives and Challenges; Establishing Trust and Managing Risk
Bowen (2013)	United Kingdom	9	Residential Therapeutic Community	Interviews	Thematic Analysis	Shared Decision Making; Social Roles; Peer Support; Open Communication

Ma et al (2009)	Taiwan	15	Acute Inpatient	Interviews	Content Analysis	Honeymoon to Chaos Stage, Positive vs Negative Outcomes, Practicing Routines, Adequate Support from Staff, Differences in Care Outcomes
Ratcliffe & Stenfert-Kroese (2021)	United Kingdom	5	Forensic Secure Inpatient	Interviews	Interpretative Phenomenological Analysis	Therapeutic Relationships. Approach and Manner, Coping in a Challenging Environment
Stroud & Parsons (2013)	United Kingdom	4	Community Mental Health	Interviews	Interpretative Phenomenological Analysis	Knowledge of BPD, Attitudes Towards BPD, Interactions with Clients, Service Context

Six themes were created from the data synthesis, all of which incorporate both descriptive and analytical elements. The themes are as follows:

1.5.3.1 The Importance of Teamwork. Studies discussed how teamwork was important to work effectively with clients diagnosed with EUPD. Nurses felt a supportive environment was one in which they could work best, thus impacting client outcomes (Ma et al., 2009). A supportive environment was evidenced by working in a unified approach, where all staff members follow the same guidelines and treatment protocols (Acford & Davies, 2019). Furthermore, teamworking was evidenced by good communication between staff members, which they felt was especially important when working with high levels of risk (Ratcliffe & Stenfert-Kroese, 2021).

It was also important for nurses to feel they can learn from each other, comparable to that of ‘continued professional development’. Studies spoke of how peer learning was key to help alleviate any stress or pressure that nurses felt (Ma et al., 2009; Acford & Davies, 2019). Receiving active help from each other was appreciated, particularly when experienced staff members offered reflections and guidance in how to respond to service user dilemmas (Ma et al., 2009). Similarly, the active help from peers also appeared to help with the nurses own mental health, when working in environments which they felt to be challenging (Ratcliffe & Stenfert-Kroese, 2021).

1.5.3.2 Maintaining Boundaries and Consistency. This theme arose in light of studies discussing the importance of maintaining professional boundaries around clients who can evoke strong emotional reactions (Langley & Klopper, 2005; Acford & Davies, 2019). Nurses spoke of the need to maintain boundaries in multiple areas of work, such as with availability of time and emotional health (Langley & Klopper, 2005). Additionally, they discussed the need for boundaries when deciding what level of personal information to share with clients and how this can be difficult when you want to maintain professionalism but also respect the client's curiosity about who they are building a therapeutic relationship with (Ratcliffe & Stenfert-Kroese, 2021).

The need for boundaries appeared to correlate to the need for consistency and stability, which nurses felt improved their practice (Bowen, 2013). Nurses discussed boundaries as important to their practice but also recognised how this may be helpful to clients. This included keeping a routine for clients who may find it hard to build trust and remaining a stable figure whom they can have open dialogue with, where this may be lacking in other areas of their lives (Bowen, 2013; Langley & Klopper, 2005). Nurses felt it was important to maintain boundaries for themselves but ultimately for the client, as they did not want to hinder their care in any way (Stroud & Parsons, 2013).

1.5.3.3 Managing Expectations of Recovery. Nurses discussed the need to manage their expectations when working with service users; both in the outcomes they expect as well as what the client may expect (Ma et al., 2009; O'Connell & Dowling, 2013; Stroud & Parsons, 2013). Nurses felt effective practice was achieved when they held consistent beliefs that the service user will improve. This was increased by showing tolerance and encouragement to the service users they worked with (Ma et al., 2009), rather than becoming consumed by negative thoughts that the client will not 'recover'. Some nurses reflected on how a lack of training makes them feel inadequate when working with clients with a personality disorder and how they have to manage their own expectations of what they can offer therapeutically (Stroud & Parsons, 2013).

Nurses' expectations were further managed by noticing the small improvements a client made, rather than focusing on the bigger picture (O'Connell & Dowling, 2013). This helped motivation levels to work with the clients, as the small achievements were celebrated by all.

Ultimately, some nurses felt that you cannot expect realistic change and improvement in a client unless you as a staff member are willing to invest time and energy into their care (Ratcliffe & Stenfert-Kroese, 2021).

1.5.3.4 Reflecting on Emotions. Within this theme, nurses consistently reported the need to manage their own emotions whilst working with this group of service users (Ma et al., 2009; Acford & Davies, 2019; Langley & Klopper, 2005). They discussed the importance of making sure they did not project any stresses they were experiencing onto their clients who may be more attuned to engagement levels or who may perceive the stresses as their fault (Acford & Davies, 2019). Some nurses acknowledged that it is important to notice and be honest about the reactions to clients with a personality disorder diagnosis that may be deemed ‘negative’, such as dread, but that they balance these feelings with the desire to help (Stroud & Parsons, 2013).

Furthermore, nurses discussed how reflecting on their own emotions with team members often led to more positive interactions with their clients (Ma et al., 2009) due to decreased levels of burnout. Alongside burnout, nurses felt that it is important to notice when you are becoming desensitised to the work as it often involves high risk situations (Ratcliffe & Stenfert-Kroese, 2021). In this instance they felt it was important to distinguish between being resilient versus being desensitised.

1.5.3.5 Viewing the Person Holistically. A way in which nurses achieved effective practice with clients was to view them holistically, rather than focusing on their current presentation. This theme reflects nurses’ ability to reflect on a client’s background and how this may have impacted their diagnosis. They felt it was imperative to get to know their clients as a person, rather than just as a patient (Ratcliffe & Stenfert-Kroese, 2021). Specifically, nurses discussed the importance of recognising trauma histories in those with a personality disorder diagnosis (O’Connell & Dowling, 2013; Bowen, 2013; Langley & Klopper, 2005; Acford & Davies, 2019; Stroud & Parsons, 2013). Nurses reported that taking account of trauma histories allowed them to maintain empathy for their client as well as engage with them sensitively, taking their needs into account (Acford & Davies, 2019; Stroud & Parsons, 2013). This then improved engagement levels with their clients and allowed them to build a therapeutic relationship.

Viewing a person holistically also involved nurses identifying a client’s strengths and not becoming consumed with the number of difficulties they present with (Langley & Klopper, 2005; Bowen, 2013). By holding these strengths in mind, nurses discussed how it helped clients to recognise other parts of their identities aside from their personality disorder diagnosis (Langley & Klopper, 2005). Additionally, by recognising strengths nurses felt able to maintain greater empathy for clients in times when their interpersonal relationship may have been challenged (Bowen, 2013).

1.5.3.6 Co-Production. The papers discussed the need to continually involve service users in their treatment to achieve the best outcomes (Ma et al., 2009; Acford & Davies, 2019; Bowen, 2013; Ratcliffe & Stenfert-Kroese, 2021). One element this involved was shared decision making about treatment options (Bowen, 2013; Ratcliffe & Stenfert-Kroese, 2021). Shared decision making involved open dialogue between service users and staff, as this allowed honest interactions about what was working effectively (Bowen, 2013).

Individualised treatment interventions were also reported by nurses as a way of engaging in effective treatment (Ma et al., 2009). The interventions were based on the service user’s unique characteristics and strengths. Nurses reflected on how positive risk-taking behaviours can be helpful for this client group, but that this needs to be co-produced between them and the service user dependent upon what they are asking for (i.e. letting them use knives in the kitchen within an inpatient service) (Ratcliffe & Stenfert-Kroese, 2021). Nonetheless, some nurses reflected on how service demands, such as lack of time and high caseload numbers, means they cannot offer the level of personalised care which they would like, as they have to prioritise risk (Stroud & Parsons, 2013).

1.5.4 - Discussion

The current literature review has revealed the self-reported ways in which mental health nurses work effectively with individuals who have an EUPD diagnosis. Nurses discussed individual factors influencing their practice such as their own emotions, expectations for treatment, boundaries and viewing a person holistically. They also reflected on wider systemic factors such as team support and coproduction with service users. The literature revealed how nurses believe these factors impact practice for themselves but also how they impact the service user simultaneously.

Whilst the literature review has highlighted many similarities in how nurses respond effectively to individuals with a personality disorder diagnosis, leading to the creation of six main themes, there are a number of limitations to be discussed. Firstly, it was hoped that more papers would have been included in this review, to improve its methodological rigour. However, the number of papers included in this review indicates the lack of research exploring effective practices for this client group. Instead, the vast amount of research in this area tends to reiterate the harmful care that is given to clients with an EUPD diagnosis. This may have also been impacted by the search terms used within the review. For example, the terms “therapeutic” “relationship” could have been influenced by the researcher’s position as a psychological professional, whereby these terms are used frequently. Thus, this may have narrowed the scope of the search, as papers which may have been critical but still presented a balanced view of staff effectiveness may have been excluded due to the ‘positive’ nature of the search terms. Secondly, due to the small amount of research into this area the decision was made to include papers from any country, rather than UK specific. Although the papers still had similarities between them, it is important to recognise that all countries will respond differently to clients diagnosed with EUPD as they follow differing mental health policies and procedures. Finally, it is a limitation of this review that a second, independent CASP rater was not used to appraise the included studies as this would have increased the quality of the review.

Nonetheless, the review has indicated that there are many ways in which mental health nurses feel they work effectively with this client group. It has investigated a novel topic area which seems to be overlooked in EUPD research. However, further research is needed in order to firstly confound the current findings and secondly explore effective practices in a number of different services and countries. Given that only four of the included studies were conducted in the UK, this highlights a gap in the current literature. Additionally, given that three out of the these four UK studies were specific to inpatient services, future research needs to ascertain how staff working in specialist community mental health teams aim to provide effective care to clients with an EUPD diagnosis in the NHS. From a systemic organisational perspective, the referral criteria, approaches and resource limitations of specialist services can work against the collaborative, relational approaches identified as good practice above. Currently, no research has explored how specialist perinatal mental health staff work effectively with mothers who have a diagnosis of EUPD, thus leading to the rationale for the current research.

Method

2.1 Chapter Summary

This chapter will outline the epistemological paradigms and chosen methodology for the current research. It will explain the processes of data collection and analysis whilst also exploring the researcher's positionality. The ethical considerations and dissemination plans for this research will then be discussed.

2.2 Epistemological Positioning

2.2.1 Ontology

Within social science research, it is important for researchers to recognise and state the philosophical positions which their research is based on. This is because these philosophical positions will ultimately inform the design of the research and the researcher's relationship with data analysis and interpretation (Clarke & Braun, 2021).

Ontology is "the branch of philosophy which deals with the nature and structure of reality" (Guarino et al., 2009, p. 1). In essence, ontology is the 'science of being' and the understanding of what we believe to exist, or not exist (Smith, 2012). Ontological positions sit within a continuum, with realist and relativist views at either end. Realists believe that there is an observable reality which can be uncovered in an objective way via research (House, 1991), whereas relativists state there is no singular reality instead multiple, co-existing realities which are socially produced (Fletcher, 1996).

The current study is informed by a critical realist ontology. Critical realism sits between realism and relativism by positing that there is a reality which exists independently from human structures but that the truth of reality is mediated and obscured by the subjective processes that produce knowledge, meaning it is not fully accessible (Madill et al., 2000).

Critical realism further states that reality can be differentiated into three domains: the empirical (constituted only by that which is experienced by individuals), the actual (the events which may or may not be experienced) and the real (the mechanisms and structures that generate events) (Sayer, 2004; Danermark et al., 1997). Thus, an individual's experience of an event may be radically different to that of another, dependent upon their subjective experiences and the social narratives they receive. Using a critical realist ontology for this research allows for an understanding that the diagnosis of EUPD is a reality within NHS mental health systems, which tends to imply realist ontological assumptions, but that individuals will hold differing meanings about this term, which can be further explored. As such, it allows for recognition that there may be different interpretations about those with an EUPD diagnosis, as how individuals interact with the experiences and issues that result in a personality disorder diagnosis will be different for all dependent upon their own subjective experiences and the social context in which these arise.

2.2.2 Epistemology

Epistemology is concerned with the theory of knowledge and is based upon philosophical underpinnings. It attempts to provide answers to the questions 'how and what can we know?'. This involves thinking about the nature of knowledge itself, its scope and the validity and reliability of claims to knowledge (Willig, 2013). For the current study a feminist epistemological position has been utilised, namely feminist standpoint theory. Feminist researchers argue that although purporting to be 'objective' and value-neutral, science has often functioned to the disservice of marginalized groups, particularly women (Stacey & Thorne, 1985). Thus, feminist standpoint theorists reject the notion that research can ever be value free (Harding, 1992) and that women's experiences have not been 'adequately represented' in social science research as they are framed within patriarchal discourses (Jardine & Smith, 1987). Therefore, social science research should seek to engage in research from the standpoint of women. Standpoint feminists state that all knowledge is socially situated and that women's ways of knowing are different to men's ways of knowing as they have a unique perspective of their own experience, on men and on the sociocultural patterns of patriarchal practices (Belenky et al., 1986). Utilising a feminist standpoint epistemological position within this research felt imperative, given the core focus of the research is mothers who have an EUPD diagnosis and perinatal staff experiences of this group. Mothers with an EUPD diagnosis are extremely marginalised in society, not only because of their mental health but also the fact they are women. Thus, this epistemological position allows for a recognition of this marginalisation. Importantly, feminist standpoint theory recognises that women can be oppressed in some situations, while at the same time privileged in others (Maxine & Thornton, 1996). This is particularly relevant to the current study as although the participants are females, they are NHS mental health professionals who arguably hold greater power and privilege than the mothers with the EUPD diagnosis whom they are discussing within their interviews.

The link between critical realist ontology and feminist epistemology can be said to be underdeveloped (Gunnarsson et al., 2016). It has been argued that some tension can arise between the two positions as the feminist desire for the voices of women to be heard and the critical realist belief that some accounts of reality are more 'salient' than others in research (i.e. the researcher chooses which interview extracts are best placed for their results) sits uncomfortably (Parr, 2015). Nonetheless, an argument has been made that feminist research should reject relativist approaches which focus on constructionist principles as using these approaches means there is "nothing to assert the existence of even the starkest material realities such as war, slavery, poverty, physical and sexual abuse which women face" (Wilkinson, 1997, p. 194). Gunnarsson et al. (2016) argues that the link between feminist research and critical realist and/or psychoanalytical paradigms needs greater consideration as there are points of harmony between these approaches which can help to further feminist research.

2.3 Design

Quantitative methods have prevailed in psychological research since its conception as a science (Gelo et al., 2008). Quantitative data is usually associated with realist perspectives of reality, however criticism towards this way of conducting research has risen in recent years (Bryman, 2016). Qualitative research which intends to generate knowledge grounded in human experience (Sandelowski, 2004) and "delve into questions of meaning, examine institutional and social practices and processes, identify barriers and facilitators to change" (Starks & Trinidad, 2007, p. 1) is associated with more relativist perspectives of reality.

A quantitative paradigm would not have been appropriate for the current research as the often positivist way that this research views reality would not have allowed for the individual experiences of the participants and meanings behind such experiences to be explored in a way which allows for differing viewpoints to be considered. Thus, a qualitative approach was utilized as it was felt to be more congruent with the aims of the current study. Furthermore, using a qualitative approach builds upon much of the existing literature outlined in chapter one, which is also qualitative in nature.

Reflexive thematic analysis (TA; Braun & Clarke, 2006) is a method for identifying, analysing and reporting themes within data (Boyatzis, 1998). Thematic analysis is independent of specific theories and epistemologies, meaning it can be applied across a range of theoretical and epistemological approaches (Braun & Clarke, 2006). King (2004) argued that thematic analysis is a useful method for examining the perspectives of different research participants, highlighting similarities and differences and generating unanticipated insights. Reflexive TA was viewed as an appropriate method for this study as it allowed a broad overview of themes to be identified, whilst also helping to ascertain relationships in participants' opinions. By using this method, it builds upon the previous research that has been undertaken in this field. However, reflexive TA has been described as a "poorly demarcated and rarely-acknowledged" method of analysis as it does not appear as a 'named' analysis in the way that other approaches do (Braun & Clarke, 2006, p. 1). Whilst there are limitations to all approaches, it is nonetheless the researcher's belief that it is still the best method to investigate this research aim.

Other qualitative approaches such as Interpretative Phenomenological Analysis (IPA; Smith et al., 1999) and Grounded Theory (Glaser, 1992) were considered but it was felt that as IPA seeks to explore very individualised accounts of experiences this was not congruent with the aim of this research which seeks to explore shared experiences from a larger participant pool, as this is a very under researched area. Additionally, it was felt that grounded theory would not be best placed given the aims of this research as although it can help to identify themes in data it was not seeking to explicitly measure social processes or derive a new theory from the results.

2.3.1 Researcher Position Statement

In line with the critical realist ontology of this research which states that subjective processes influence our view of reality, it is crucial that researchers recognise and explore their position within the research, as this ultimately impacts how data is sought and analysed (Braun & Clarke, 2019). This process is also known as reflexivity which Willig (2013) defined as "reflecting upon the ways in which our own values, experiences, interests, beliefs, political commitments, wider aims in life and social identities have shaped the research" (Willig, 2013, p. 55). Throughout the research, the researcher kept a reflexive diary of judgements, practices and beliefs that arose so as to comply with the reflexive approach outlined by Braun and Clarke (2006). To maintain reflexivity with this research, the researcher will now outline their positionality.

I am a 27-year-old white British female and a trainee clinical psychologist. I am an only child from a working-class family. Before training, I completed an undergraduate degree in psychology and a masters in psychological research methods, both of which I see as the starting point of my journey into psychology. Once I finished my masters, I completed two assistant psychologist (AP) posts within the NHS which undeniably impacted who I am as a person, a trainee and a future clinical psychologist. Similarly, these experiences have informed multiple elements of this research, namely the initial interest of the topic area and the interpretation of the results.

My first AP role was in an adult acute inpatient ward, for both males and females. It is hard to summarise the experiences you gain from working with individuals who are amidst a crisis in their mental health but I remember feeling grateful to be able to witness the strength and resilience which was so often exhibited. Within this hospital, it was not uncommon for individuals to have a diagnosis of EUPD. What was more common, however, was that the female ward had a much higher rate of individuals with this diagnosis than the male ward. At the time, being in my early twenties and new to world of psychology I remember noting this contrast but did not think about it much further than that. I remember hearing certain staff members talk about these clients in ways which sat uncomfortably with me but I also recognised that I was not working on the wards for 12 hour shifts (as the nursing staff were) and that I was in a privileged position as an AP as I could leave the ward when I wanted. It seemed that the unhelpful narratives I was hearing about these women often originated from a place of burnout, stress and lack of trauma-informed training.

Moving into my second assistant psychologist post, I worked in a children and adolescent dialectical behavioural therapy service, where individuals had to be actively suicidal or self-harming to meet entry criteria. As aforementioned in chapter one, within the UK it is generally not advised to give adolescents a diagnosis of EUPD, so they did not receive one in this service. However, it sat uncomfortably knowing that if they were to reach adult services, they would receive this diagnosis based on their current symptomology. I remember entering this role and being shocked by the amount of adolescents accessing this service and the level of self-harming and suicidal behaviour they exhibited. When reading their case notes you would often, but not always, read histories steeped in developmental trauma. The adolescents would remain in the service for either six months or one year of treatment and their parents/caregivers were required to attend a weekly DBT skills group with them. Developing relationships with these young people for an extensive amount of time was a privilege. In my personal experience most of the young people that entered the service left after one year in a completely different place to where they started, for the better. Yet, I was often left wondering how their lives would be as they enter into adulthood and if they were to become parents, given the often traumatic experiences they faced in childhood.

From these experiences this research idea was created. If I had not have had these AP opportunities it is unlikely that I would have decided to research the area of EUPD and motherhood. My personal encounters are inextricably linked to all areas of this research design. Given the narratives I have heard about women who receive an EUPD diagnosis, I was acutely aware of not wanting to perpetuate the dominant narrative of what is ‘wrong’ with these clients when designing this project, which is why the aim was to look at what works ‘effectively’ for staff who work with these women.

Currently, I do not have children and I have never worked in a perinatal service. Thus, I have both an ‘insider’ and ‘outsider’ perspective of this research. I was an insider given that I have had experiences of working with adults who have an EUPD diagnosis but I am an outsider in the sense that I have never worked with mothers with this diagnosis and I am not a mother myself. Nonetheless, I identify as a female, who is interviewing females about working with mothers. I had always known that it was imperative for me to bring a feminist stance to this research, given I was passionate about this area. Throughout this process I have had to reflect on my assumptions, biases and judgments about what it means to be a female and a mother in UK society and I hope this positionality statement has provided a sense of transparency as to how and why I have approached the following research in the way that I have.

2.4 Procedure

2.4.1 Recruitment procedure

Ethical approval was granted by the University of Essex and the Health Research Authority for one NHS trust in East England (Appendix A and Appendix B). The Participant Information Sheet (Appendix C) was purposively emailed to the lead perinatal psychologist by the researcher and asked to be circulated to the perinatal team practitioners/care-coordinators and team managers. Being a trainee clinical psychologist, it was easier for the researcher to obtain the details of the qualified psychologist in the service which is why the study information was initially sent to them. The researcher asked for confirmation when the information had been circulated to the team, which was provided. When recruitment proved slow, the researcher asked the participating service if it was possible to attend multidisciplinary team meetings, which were all held online, to advertise the study face-to-face. A total of three meetings were attended which helped recruitment but further participants were needed. Therefore, the decision was taken to expand the inclusion criteria from only recruiting practitioner/care-coordinator staff to anyone working in a psychologist role. Additionally, at the same time as expanding the inclusion criteria the decision was taken to amend ethical approval (Appendix D) in order to recruit from two more NHS trusts in East England. Therefore, a total of three NHS trusts were now included in the research. This improved recruitment speed but the lead psychologists in all participating trusts had to send out the information sheet twice before an acceptable number of participants were finally recruited. Given more time, it is likely that more participants could have been recruited to the study but the researcher had to decide what was an acceptable number of participants before ending the recruitment phase as they needed enough time to complete data analysis.

2.4.2 Research procedure

Participants who expressed an interest in the research after reading the participant information sheet were directed to call or email the researcher using the contact details provided. During this initial conversation, if the participant met eligibility for the study based upon the inclusion and exclusion criteria they were invited to an interview at a mutually agreed time and date and they were sent a consent form to sign and return the day before the interview commenced (Appendix E). Individual interviews were chosen as the method of data collection, rather than focus groups, as previous research has highlighted how individuals with a personality disorder diagnosis can incite emotive opinions in staff (Newton-Howes et al., 2008) meaning participants may have felt more comfortable expressing opinions away from their colleagues. Participants had the choice between a telephone or video call interview, with all interviews taking place via Microsoft Teams video conferencing software at the participants’ request. University ethics required interviews to be held remotely as a result of the Covid-19 pandemic. Whilst England was not in lockdown and society was entering the phase of ‘living with Covid-19’, it was advised at the time of writing the ethics application that research was still conducted remotely when possible.

At the start of each interview informed consent procedures were reiterated and the researcher asked participants to confirm they were in a confidential and comfortable space. Participants were required to use their own judgement of what case examples to bring of mothers who have been diagnosed with or meet the criteria for an EUPD diagnosis, as the researcher did not have access to the perinatal team caseloads for ethical reasons. They were asked to reflect on experiences from the last two years as this was likely to increase the accuracy of their recollection given they were more recent experiences. At the end of the interview, the researcher gave a debrief which ensured participants had the opportunity to ask any questions, give feedback on how they found the interview process and thanked for their time. They were also reminded that they can contact the researcher via email if they would like to receive a copy of the final results.

Interviews were audio recorded using an encrypted Dictaphone and lasted for an average of 50 minutes. The transcripts followed an orthographic style, which focuses on spoken word and non-semantic sounds such as inflections, breaks, pauses and tones (Clarke & Braun, 2013).

2.5 Materials

The use of semi-structured interviews in thematic analysis is highly prevalent (Bradford & Cullen, 2012). This style of interview has been found to be effective in qualitative research as although an interview schedule is prepared, “there is scope for the participants to raise issues that the researcher has not anticipated” (Braun & Clarke, 2013, p. 24). As a result, the interview should represent a flowing conversation (Rubin & Rubin, 2011). Using an interview schedule allows the researcher to guide the topic of conversation whilst also allowing the participant to discuss issues which are relevant to them (Choak, 2013). Thus, although the schedule should guide the interview, it should also allow relevant topics of conversation to arise which had not been anticipated by the researcher (Choak, 2013). The interview schedule for the current study (Appendix F) was designed by the researcher, with advice being given by thesis supervisors. It was designed using the themes that arose in previous research, whilst also incorporating novel questions that were yet to be explored in current research. By meeting this balance, it was hoped that the questions would incite new information from participants. The interview schedule was devised in two halves, the first to explore the primary aim of how perinatal mental health staff work effectively with mothers diagnosed with EUPD and the latter half to elicit responses in relation to the secondary aim of how perinatal mental health staff perceive the adequacy of service provision for mothers diagnosed with EUPD. Open-ended probing and follow-up questions were used during the interviews to allow respondents to elaborate on the material they had discussed (Harvard, n.d). Furthermore, the researcher mirrored back phrases said by participants, in order to ensure they were being understood correctly. The researcher asked questions in a conversational manner to help put participants at ease, rather than feel like they were being 'interviewed'. It was also hoped this would help with power imbalances, as the researcher can be assumed to hold greater power than their interviewee as they are the one who has devised the interview schedule. This was another reason why it was important to not rigidly follow the schedule but instead be guided by the topic of conversation, providing they were relevant to the research aims.

A demographic sheet (Appendix G) which had been created by the researcher was used to collect demographic information about participants at the start of each interview.

To code the interview data, NVivo 13 software was used which was freely available to use from the researcher's university.

2.6 Method of Data Analysis

Data analysis was conducted using the six stages of reflexive thematic analysis evidenced by Braun and Clarke (2006, 2019). The stages are as followed:

1. Familiarisation with the data: This required the researcher to fully immerse themselves in the data by listening to the audio tapings, transcribing the interviews and then reading and re-reading the transcripts. This allowed the researcher to begin making initial familiarisation notes using the ‘memo’ function on NVivo and by-hand (Appendix H) which helped to ascertain any dominant narratives in the data.

2. Generating Initial Codes: As the researcher was now familiar with the data, they started to identify preliminary codes which featured data deemed ‘interesting and meaningful’ using NVivo software (Appendix I). The codes were selected if they appeared relevant to answering the research question. Coding was broad so as not to discard any data which may have been important to help answer the aims of the study. To ensure rigour, the researcher engaged in two coding runs (Braun & Clarke, 2021). On the first run the researcher systematically coded their way down the interview data set. On the second run, the researcher started in the middle of the dataset and then worked their way up the dataset before moving onto the latter half of the dataset. This process is used to reduce the risk of order effects. Codes were then refined to ensure there was not any overlapping or repeated coding.

3. Searching for Themes: Once coding was complete, the researcher printed all of the electronic codes and cut them into individual strips of paper. This was so they could then begin to combine relevant codes into overarching themes. Themes can be defined as ‘broader patterns of meaning’ which are evident in the data. Some codes needed to be

disbanded or separated in order to allow the construction of themes. This process was completed by hand (Appendix J), with an extract of the researcher's reflexive diary being given below, in order to outline the reasons as to why the decision was made to swap between electronic and manual data analysis:

I grappled with the idea of coding on NVivo verses coding by hand for a long time before beginning the process. The consensus I was gaining from textbooks was that it is ultimately the researcher's preference. The thought of coding by hand left me feeling slightly overwhelmed and in previous projects I have always used NVivo (albeit they were not to this scale). Thus, I made the decision to begin coding electronically and if I felt uncomfortable with this I would swap to hand written coding. When it was time to begin stages three and four of theme development I instantly gravitated towards a manual, hands-on process. Seeing hundreds of codes on a screen was overwhelming to look at and I felt it could not do the theme creation justice. Thus, I made the decision to print, cut and move the codes around by hand when creating my themes. For me, this made the process more tangible and exciting – giving me something I could physically 'play' with when toying with different ideas and formations. I feel this blended method of both electronic and manual analysis suited me best.

4. Reviewing Themes and Sub-themes: The researcher then conducted a deeper review of the themes which allowed them to define, refine, separate and discard the initial themes created. The themes were refined in this way to make sure that they were an accurate, detailed, meaningful pattern of data and represented the codes well.

5. Defining and Naming Themes: The researcher then named and defined themes in a way which captured the essence of what the data entailed. Braun and Clarke (2013) encourage creativity when defining theme names which captures the attention of the reader whilst also communicating an important aspect of the theme.

6. Producing the Report: Finally, the researcher narratively presented the data in the form of a coherent report. The researcher chose interview extracts which they felt provided a vivid and compelling account of the arguments being made. The researcher ensured that extracts were provided from the entire pool of the dataset to convey the diversity of expression (Byrne, 2021).

This thematic analysis was predominantly inductive in its approach as the themes and results were derived from the data provided by participants (Braun & Clarke, 2013) rather than a pre-existing framework. Nonetheless, it was deductively influenced by the feminist epistemology within which this study is situated. Both a semantic and latent approach to analysis was utilized when analysing the data, that is themes are produced from the explicit meaning in the data as well as beyond the data to the underlying ideas and assumptions that may inform a participant's view (Braun & Clarke, 2006; Byrne, 2021).

2.7 Participants

A total of 13 participants were recruited into this study. Fifteen participants were aimed to be recruited but, as mentioned above, recruitment proved challenging. The reasons for this will be further explored in the study limitations section in chapter four. Nonetheless, recruiting 13 participants meets the pre-existing thematic analysis guidelines which state that saturation of the data is commonly reached between eight and 16 participants (Guest et al., 2006). In regards to sampling, a criterion purposive sampling strategy was employed. This can be defined as the intentional selection of participants based on their ability to elucidate a specific theme, concept, or phenomenon (Robinson, 2014). Thus, participants were selected based upon their own expressions of interest to participate and whether they met specific inclusion and exclusion criteria. Additionally, a snowballing method was used by asking participants at the end of their interviews whether they would be able to promote the research in team discussions. The demographic data of participants can be found in Table 4.

2.7.1 Inclusion Criteria

Criteria was selected as a result of the literature search and aims of the current study. Participants were included if they worked in a community perinatal mental health team and had experience of working with mothers diagnosed with EUPD. They were required to speak English and must have been willing to take part. Participants were included if they worked in a practitioner/care-coordinator role or was a member of the psychology team. These professions were chosen as they have the most consistent contact with service users each week, meaning they were likely to have a wealth of experiences to explore.

2.7.2 Exclusion Criteria

Participants were excluded from the study if they had worked in the perinatal service for less than 12 months. This was because they would have been unlikely to have a multitude of experiences working with mothers diagnosed with EUPD during this time. Participants were also excluded if they worked in a mother and baby unit or parent-infant team. This was due to the fact these staff members were likely to have very varied experiences compared to those working in the perinatal community teams, as the services follow different procedures and designs.

2.8 Ethical Considerations

Full ethical approval was granted by the University of Essex Science and Health Faculty Ethics Committee and the Health Research Authority (HRA).

2.8.1 Informed consent

Informed consent ensures participants have an understanding of the research being conducted and the possible risks it may pose (Manti & Licari, 2018). Participants received the participant information sheet which encouraged them to contact the researcher by telephone or email if they had any questions prior to consenting. Participants were required to sign the consent form before the interviews were conducted. As the interviews were conducted online they were asked to send an electronically signed consent form to the researcher via email before the interview could commence.

2.8.2 Confidentiality

Confidentiality in qualitative research ensures that data is collected anonymously without any identifying information so that the identities of participants are not compromised (Kaiser, 2009). After each interview the audio file was transferred to the University of Essex secure drive on an encrypted laptop. The researcher transcribed each audio file at the earliest available opportunity after the interview had been completed so that the audio file could then be deleted. All files were stored as password protected documents and any identifiable information was removed from the transcripts. Participants were given a pseudonym which was then assigned to their transcripts and demographic data to maintain their anonymity. This meant if they decided to withdraw from the study the correct data could be removed. All consent forms and demographic forms were electronic meaning they too were saved to an encrypted password protected computer. Participants were made aware in the information sheet that only the researcher and their two supervisors would have access to the data files during the research process.

2.8.3 Risk of harm

A risk assessment was conducted as part of the ethics process which revealed low risk to participants. Nonetheless, the participants may have wished to reflect on emotive experiences during their interview. However, they willingly bought the topics for discussion and were not encouraged by the researcher to describe emotive experiences. The researcher monitored level of distress throughout the interviews and no participants appeared to be, or stated that, they were distressed at any point. The researcher ascertained the channels of support that were available to participants within their service, such as supervision and staff reflective groups, and encouraged them to use this support if needed.

For the researcher, all interviews were conducted remotely so there was no risk of lone working. The researcher is a trainee clinical psychologist who is used to working in emotive environments and attended monthly supervision with their academic supervisors where they were able to discuss their wellbeing. The researcher did not experience any psychological distress as a result of the interviews.

2.8.4 Quality Assurance

Yardley (2000) outlines assessment criteria for evaluating the quality of qualitative research. The researcher embedded these criteria within the research during design, analysis and interpretation to strengthen the rigour of the results. The criteria are outlined below:

1. Sensitivity to Context: To ensure sensitivity is achieved, the researcher should actively consider their general actions and characteristics on the research process. The researcher kept a reflexivity diary throughout to ensure this was maintained. They have presented their positionality statement and elements of the reflexivity diary

throughout the thesis, to aid transparency for the readers.

2. Commitment and Rigour: Yardley (2000) argues that commitment to the research is maintained by the researcher fully immersing themselves in the data. The researcher worked independently on all elements of this research and had close dialogue with their academic supervisors. They conducted all of the data collection, analysis and interpretation allowing them to fully immerse themselves in the research process. Additionally, they transcribed each interview themselves, allowing an in-depth level of familiarisation with the data to occur.

3. Transparency and Coherence: This criterion relates to disclosing all elements of the research process and the researcher reflecting on what characteristics impacted the investigations. As mentioned above, the researcher has upheld the reflexivity process throughout.

4. Impact and Importance: To ensure the quality of a study, its usefulness and impact should be considered (Yardley, 2000). This research will contribute to a better understanding of the experiences of perinatal mental health staff and any areas where perinatal service provision can improve to better meet the needs of both staff and service users. It is hoped that this research will be disseminated to clinicians and perinatal services in order to promote ways of working effectively with mothers who live with an EUPD diagnosis. Further details regarding dissemination plans can be found below.

2.9 Dissemination

Given the importance of the research findings, it is imperative that the results are disseminated. The lead psychologists within the participating trusts requested a copy of the results and the researcher plans to attend team meetings so that they can present the findings to the staff teams in person. By doing so, teams may be able to adapt service provision at a local level, dependent upon the findings and implications of the research. The researcher will be presenting the results at the University of Essex’s Staff-Student Research Conference and will make plans to disseminate their research at perinatal mental health conferences in England, such as those run by the faculty of perinatal psychology within the British Psychological Society (BPS). Furthermore, the researcher endeavours for this research to be published in a scientific journal(s), with the Journal of Personality Disorders and the Journal of Prenatal and Perinatal Psychology and Health being particularly pertinent for this piece of research. Arrangements will be made for these submissions in due course.

Results

3.1 Chapter Overview

Within this chapter, the results of the current study will be presented. Participant demographic information will be provided including age, job title and time spent working in the service. Then, key observations from the authors reflexive diary will be recounted, specifically focusing on interview reflections and the write-up of results. Further, the six main themes and 13 sub-themes are then presented and discussed. Verbatim quotes are used throughout this section to confound theme interpretations.

3.2 Participant Demographics

Thirteen perinatal mental health staff participated in this study. A further three people expressed an interest in participation but did not arrange an interview. This was because one person did not respond to communication after making initial contact, one person could not find a suitable time to attend due to workload and one person did not attend their planned interview with no further communication given. The demographic information of participants can be found in Table 4. Where possible, demographic information has been grouped into categories to help maintain confidentiality and anonymity. This is because participants working within the same team may have been able to identify each other based on individual demographic information.

Table 4

Participant Demographics

Demographic	**Category and Number of Participants (N)**							
Job Title (Core profession at the time of interview)	Mental Health Nurse N = 4	Clinical Lead Nurse N = 3	Occupational Therapist N = 1	Assistant Psychologist N = 1	Counselling Psychologist N = 1	Clinical Psychologist N = 1	Perinatal Mental Health Worker N = 1	Deputy Manager Social worker N = 1
Ethnicity	White British N = 10	White Other N = 1	Black British N = 1	White Irish N = 1	-	-	-	-
Time in Service (Months)	12 – 24 Months N = 7	25 – 36 Months N = 2	37 – 60 Months N = 4	-	-	-	-	-
Age	25 – 32 N = 2	33 – 40 N = 7	41 – 50 N = 4	-	-	-	-	-
Years Qualified	N/A N = 3	9 – 15 Years N = 7	16 – 25 Years N = 3	-	-	-	-	-

The sample was unevenly distributed in terms of sex, with all participants being women. No males expressed interest in participation, which perhaps reflects issues with recruiting and/or locating males who work in perinatal mental health services. The mean age of participants was 38 years of age and the average time working in the service was 32 months. The mean years qualified in their respective professions was 11 years.

3.3 Reflective Notes

When I reflect on the participant interviews, I was left with a feeling of hopefulness. Participants spoke with great eloquence and care regarding service users, I was somewhat taken aback by how different their narratives were compared to some of the more traditional views within wider literature on personality disorders. However, I hope that participants felt able to share their true thoughts with me and not what they thought I wanted to hear (given they had an understanding of the research title). In discussion with my supervisors, we thought about how more hostile feelings regarding service users may have felt too unsafe for staff to discuss but there was a strong commonality of being able to discuss more hostile feelings towards other services, as will be evidenced below. Nonetheless, I do believe I had a ‘felt-sense’ of their passion towards their service users and they were simultaneously able to recall dilemmas which they can face with this client group.

An observation that I continued to make during the interviews was the similarity of narratives between participants. I was surprised by how their experiences seemingly over-lapped, despite working in different services. When reflecting on my role within the interviews I felt able to build a rapport with all of my participants and I wonder how being another NHS member of staff, who was also a female, impacted this process. Having never worked in a perinatal service, I think this was a help rather than hinderance, as it meant I did not bring any preconceived ideas about what these services may look like. If I had have worked in a perinatal service, I can imagine it would have been hard to disentangle my own views of service provision from participants, which ultimately would have created a large amount of bias. Furthermore, the fact that participants would have been aware from the information sheet that I am trainee clinical psychologist I believe helped with rapport building as they knew that I was an NHS member of staff and they would have likely worked with people who have this role within their own teams. However, I question how being a trainee may have also hindered the process. For example, if participants wanted to discuss areas of psychology provision within their interviews they may have censored or decided against sharing their views, knowing that I am a psychological professional. From my perspective, I also wonder how my title of a trainee clinical psychologist may have impacted the power dynamics within interviews. For example, within the NHS banding pay system, the majority of participants would have been a pay grade higher than me, and as such, hold more ‘power’ within the NHS system. Perhaps this may be why they felt able to agree to interviews, than those who would have been of a lower banding than me, where it may have felt like I was holding more power.

Additionally, it is important to reiterate that I am a white British female and the majority of my participants were also white British. Whilst I do not have any answers, I question how much this helped with rapport building, given that all of my interviews were conducted via video call, where I was visible on-screen. In regard to video calls rather than telephone calls, I feel this may have further helped with rapport building as body language is such an important aspect of human interaction. Within myself, I noticed a sense of burden that I was holding when interviewing NHS staff. I felt ‘bad’ for taking up their time, given the sense of how busy they were, with time pressures of their work being discussed in most interviews. Nevertheless, I held in mind that participants had volunteered to participate and that they were gaining something from the process too. Notably, at the end of the interviews several participants said it felt good to talk about their feelings, indicating it felt like a reflective space for them to have engaged in.

Within the context of analysis write-up, the process of choosing pseudonyms came to fruition as I started this process. I thought it would be easy to select names and yet I must have been feeling some resistance to the task as I found myself googling ways to assign participant pseudonyms. It was during this process that I came across a paper by Lahman et al., (2015) that made me acknowledge an uncomfortable dilemma. I had not thought to ask participants to assign their own pseudonyms before the interviews begun. Alas, I had to assign them myself but wanted to give meaning to the process. Therefore, the pseudonyms I assigned were based off a category of geographical ‘places’. I chose this category as there was a felt sense of cohesion between my participants, as they were all perinatal mental health staff, yet they are distinct in their own right. As such, although there is a cohesion from the category of ‘geographical places’, the places chosen were from separate cities, to help keep them ‘feeling’ distinct. Additionally, I have tried to keep the pseudonyms as close to the ethnic origin of participants as possible.

3.4 Thematic Analysis

The analysis identified six themes and 13 sub-themes (Table 5).

Table 5

Overall Themes and Sub-themes

Main Theme	Sub-theme
Let's Talk About Labels	Advocation for Complex Trauma Medical Model Critique Recognizing Intersectionality
We're in This Together – The Work is Relational	Mirroring a Healthy Relationship Using an Attachment Focused Lens
The Fit Between Staff and Service	What Do I Bring to the Work? Acknowledging the Team Identities
The Importance of Feeling Valued	Reciprocal Appreciation Leading By Example Feeling Part of a Team
Trying to Navigate a Complex System	The Constraints of Time Having to be a Jack-of-all-trades
Where Does the Responsibility Lie?	The Domino Effect The Invisible Women

3.5 Theme One: Let's Talk About Labels

This theme captures participants' narratives regarding the importance of terminology and labelling within perinatal mental health services and the ramifications this can lead to for service users. Furthermore, participants explored the use of labels more broadly, aside from just diagnoses, to illustrate their beliefs about how the medical model interacts with social identities. Within this theme, three sub-themes were created: Advocation for Complex Trauma, Medical Model Critique and Recognizing Intersectionality.

3.5.1 Advocation for Complex Trauma

The majority of participants expressed a desire to use the term complex trauma and/or complex PTSD in place of EUPD. This was an overwhelming thread within most interviews, regardless of job role and team locality. Many felt that by using the term complex trauma, it accounts for the often traumatic histories that women diagnosed with EUPD have lived through, as discussed by India. Additionally, Chelsea illustrates how it can open up conversations regarding strengths within these women.

> *"I suppose, I kind of try to think about it in terms of a complex trauma or PTSD umbrella is my kind of thinking. So I usually think that anybody who has a diagnosis of personality disorder has usually undergone some kind of attachment trauma or some kind of difficulty that's just made them cope in a different way which can sometimes be self-destructive or viewed as destructive to others or unhelpful to others, erm, or in a way that people find hard to tolerate. That's my thinking around it." (India)*

> *"Particularly these mothers that we're working with you know they've been through some really hideous situations and that makes them so resilient. So I think there's a lot of strength to the diagnosis [complex trauma] too, they are survivors." (Chelsea)*

Nonetheless, participants were honest about their journey with the terminology of EUPD and complex trauma. Many felt that working within a perinatal service allowed them to refrain from using terms which they used to be uncomfortable with in general mental health settings. Chelsea and Elizabeth explain that a compassionate approach within perinatal has allowed for this change to happen.

> *“I guess my thoughts have really changed since coming into the perinatal team. Erm, when I worked in sort of acute services and we saw a lot of people with personality disorders on the ward, I felt like the diagnosis wasn’t really understood or there wasn’t a lot of compassion around it. Whereas in the perinatal team it’s such a compassionate service. The service really understands the experiences of a person and what has led them to present in this way or behave in this manner.” (Chelsea)*

> *“So it doesn’t get thrown around [EUPD] because we understand that women have so much to cope with and have so many challenges. Erm and so when patients are particularly difficult there’s just more of a compassionate approach to that rather than saying ‘oh they’re a PD’” (Elizabeth)*

Furthermore, as participants felt that perinatal services have a compassionate view towards trauma, they discussed how the conversations regarding complex trauma and its associated terminology is nurtured through continued professional development. It is notable that Charlotte and Florence work in two separate services, yet both perinatal teams are engaging in a process of learning.

> *“One of the pieces we’re doing with (Assistant Psychologist), she’s doing a brilliant piece of, err, visual, describing what we mean by complex needs and that’s now gone to all of the teams bases so that’s up in the office.” (Charlotte)*

> *"I think there is a complex PTSD perinatal two-day course and that is really really good training. And everyone has to do it who comes into the team. And people have been on it and said to me how they're going to change now that they've been on it and how it's really opened their eyes." (Florence)*

3.5.2 Medical Model Critique

The second sub-theme appears as a direct result of participants' advocation for the use of complex trauma. Due to participants using the term complex trauma they question traditional medical model practices and the 'status-quo' of mental health narratives. Participants expressed concerns towards traditional EUPD diagnoses and how it seems to blame individuals.

> *"I think the term personality disorder could be, er, it could sound quite derogatory and I think that's what people perhaps struggle with being diagnosed with because it sounds like you're making a judgement on the person's personality rather than explaining that it comes from these sort of complex trauma situations" (Kendall)*

In line with this view, Madeline speaks of how blaming individuals for their mental health can lead to stigmatisation from services.

> *"But often what happens and I think, I think, I hope it happens less in perinatal than it does in other places but as soon as I guess people get kind of tarred with the personality disorder brush I think often their emotional experiences, their distress, their care seeking, it's really seen with a very distorted lens and people start to talk about women as a bit personality disordered, a bit EUPD, erm manipulative, dependent, and all of those kind of things and I think we lose, we can as services tend to lose a lot of empathy for people with that diagnosis." (Madeline)*

By questioning the EUPD diagnosis, some participants discussed how they have begun to question the purpose of diagnosis generally. This can be seen in Chelsea and Clare's accounts below, with Clare reflecting on the role of gender. She seemingly considers the impact of a patriarchal society within medical practices, as she alludes to the impact that would be felt if men were more likely to receive this diagnosis.

> "*So I tend not to focus so much on the diagnosis and instead the impact on functioning. Erm and I think there's a conversation around diagnosis which is important, but it actually, it doesn't matter because it's how your feeling. It's how you're experiencing the world, it's how you respond to certain situations." (Chelsea)*

> *"So it's so far behind so many parts of medicine at the moment [EUPD diagnosis], erm, and it does make you wonder there's a lot of women with this diagnosis, is that why they're so far behind in making some positive changes?" (Clare)*

However, whilst many participants felt able to express their concerns of certain medical model practices, they also highlighted that the medical model cannot be avoided and so it ultimately impacts their practice. There is a sense within their stories that the systems perpetuating EUPD narratives are too large to tackle as individual clinicians.

> *"So working within the NHS when you're working with very very experienced consultants I think it can be challenging talking about not calling it a personality disorder." (Morgan)*

> *"It's very much a medical model and is there any sort of desire to make that change? I know when we first had our perinatal consultant I was asking her four years ago to start that change and she said it's going to be a very gradual one and she's right, it has been, it still is! Four years on." (Clare)*

Finally, Florence discusses how certain professions within her service, namely psychology, feel able to move away from medical model narratives but that overall the team position is different. This implies a tension between differing professional identities and the terminology which they may or may not use. She was asked whether the rest of her team use the term complex trauma, as this was her preferred diagnosis to use with service users.

> *"It doesn't, not really no. It does maybe within psychology but not within the team in general. The team in general tend to go with personality disorder." (Florence)*

From the narratives presented in this sub-theme, it seems there is a discomfort in labelling clients with EUPD. Whilst this comes from good intentions using a trauma informed lens, this is important to recognise if a client takes comfort from their EUPD diagnosis. It would be important not to minimise the relational and emotional difficulties that arise from experiencing trauma by avoiding certain EUPD terminology.

3.5.3 Recognizing Intersectionality

The final sub-theme summarises participants' awareness of working with differing aspects of intersectionality; specifically class, gender and power. Examples of three further constructs that women can be defined by. Not only do several participants recognize the different intersections their service users diagnosed with EUPD hold, they speak of how this impacts their clinical care; both from themselves as individual practitioners but also at a wider system level.

Some participants discussed the importance of class for women who receive a diagnosis of EUPD, as illustrated by Morgan and Eden. Both participants work in separate perinatal services but their services are located in what could be described as affluent localities. Thus, it could be questioned whether class and social status may be more noticeable in these teams as those who can be described as being from a lower class background may be more distinct amongst their middle/upper class counterparts.

> *"So, erm, I mean I'm very clear on this. Women who come from a lower working class are usually diagnosed with EUPD and women who come from middle class, we work with a lot of women who come from a middle class or upper class, and they all, I'd say 80% of them have a diagnosis of bipolar not EUPD. I continually question that and bring it up in our multidisciplinary team meetings that they appear to have the same symptoms, they can get angry very quickly, very irritable very quickly. Um but yet these women are treated with compassion, and support, and care and treatment from a multidisciplinary team which includes psychologists, psychiatric consultants and these other women from lower classes are diagnosed with EUPD." (Morgan)*

> *"And I think how affluent the borough is has a big impact on the diagnosis and how much people seek help or don't seek help. I think it's a lot easier I think if people live in a deprived area and have a diagnosis of EUPD it's a lot easier for them to come to the attention of services then someone who lives in a big mansion." (Eden)*

In Morgan's account, it could be said that there is an assumption being made that receiving a diagnosis of bipolar disorder is better than receiving a diagnosis of personality disorder, which is why the middle class women receive this diagnosis, as perhaps it does not have as many consequences. If so, this reinforces the notion that EUPD leads to higher levels of stigmatisation and as such it is a diagnosis you would want to avoid receiving.

Eden then acknowledges the implications that a lower class background may have on women who enter the perinatal service, which ultimately impacts their treatment.

> *"I think with a couple of exceptions most of the mums I've worked with, with EUPD have been from more of a deprived demographic […] but yeah I think that the impact of that I guess when someone doesn't have a stable base, or housing problems or financial worries and they're not stable in their relationship and things I think their symptoms are much*

> *more likely to be activated and prevalent in comparison to someone who has quite a comfortable home life. And I think the motivation to do any work is higher if they don't have those other worries going on." (Eden)*

Additionally, many participants discussed the importance of remaining aware of how women are viewed at both a service and societal level, when working with a female client group. Participants discussed how, largely, the onus seems to be on women to take responsibility for their mental health during the perinatal period. Charlotte examines the decision to exclude fathers within the perinatal model and how this impacts all involved.

> *"The perinatal model for me from the outset did a disservice to families because it was predicated on the maternal mental health. Whereas we know when the baby arrives it's a family unit. And so what happened then is that the development of the service went down the maternal line and excluded partners and fathers in a way that I think did a disservice or does a disservice because we would very much want to work with the fathers and partners but we are constrained by the fact that currently the model is erm we don't see them." (Charlotte)*

When asked why she thought the model was set up in this way, Charlotte reflected on societal influences that might be at play. Namely, the way society views the role of a mother and father in parenthood and the differing levels of responsibility they hold.

> *"I think there's something about this is the mother's responsibility. You know we think about some of the narratives around what it means to be a mother and somehow fathers are you know periphery and I think that's a societal thing as well." (Charlotte)*

This corresponds to a feminist critique of motherhood and how the discourses surrounding increased responsibility on mothers is further amplified by social policies and service design; such as perinatal services only working with women. Participants also recognised that the sense of responsibility towards women is further heightened if partners do not want to be involved in the work.

> *"What we find is that generally they're not very available or interested [fathers] and again I feel like sometimes we feel like you find that some mums are very very up for getting their partner involved and then they get upset if they don't want to be involved." (Eden)*

Finally, various participants acknowledged power dynamics within the working relationship. Florence and Clare accept that they hold greater power in the relationship with their service users, which is interesting given they are both women, who are working with women. Therefore, gender does not seem to be the deciding factor, rather the fact that they are NHS staff as Florence alludes to. Clare discusses commonalities in the relationship, which may help to balance perceived power.

> *"Doing home visits I think really helped because you're going into their, and I think this is the same for all individuals I've done home visits with, you're going into their comfort zone and their space, erm, rather than because really clinics or NHS locations are not really neutral ground because you're holding a lot more of the power." (Florence)*

> *"And maybe we've got that that comparison that a lot of us are mums already. And I think that kind of, I think the mums like to be honest. They like that they've got something in common with us that isn't just their mental health." (Clare)*

Of note is that although some participants stated they were mothers, as Clare does above, they did not discuss whether their lived experience of motherhood makes aspects of the perinatal work more difficult, or the specific ways in which it influences their practice.

3.6 Theme Two: We're in This Together – The Work is Relational

The second theme reflects participants' experiences of engaging in relational work with mothers who receive an EUPD diagnosis. 'We're in This Together' captures participants' awareness of how they are personally invested in the work and the requirements they have to meet to immerse themselves in relationships on a daily basis. Participants reflect on the reciprocal nature of their work, which puts them at the centre of instilling change. This theme leads to two sub-themes: Mirroring a Healthy Relationship and Using an Attachment Focused Lens.

3.6.1 Mirroring a Healthy Relationship

All 13 participants discussed the relational element of perinatal work, specifically for mothers who receive an EUPD diagnosis and how this relationship needs to mirror one which is considered healthy and functional, so that the mothers have a template to follow in their interactions with others. They acknowledge that many of these mothers may struggle to engage in relationships due to the likelihood of relational trauma in their histories. Thus, participants speak openly about the thought processes that drive their relational decision making and how it may benefit the mothers.

One element which participants felt helped to build the relationship was the notion of 'walking alongside' the mothers, rather than taking a directive or authoritarian approach. This is reflected in Elizabeth's account.

> *"I think the main thing has just been not going in with an agenda and kind of going in as just I'm just going to walk beside you and see what happens and see how we feel and not kind of going in and being like right we're going to do x, y, z we're going to do this piece of work and I'm going to make everything ok, you know, yeah I think that's the probably been the best most helpful thing." (Elizabeth)*

However, some participants recognised that whilst this approach is needed, there is a balance between not taking too much of a lead but also knowing when to give gentle guidance.

> *"I'll make jokes, I'll play with their children, I'll sit with them in silence if they want, like I'm not pushy so it's just reading the room isn't it. It's knowing when to give a little push or shove like 'come on you can do this' and when to hold back and sit with that difficult emotion. It takes years of practice." (Chelsea)*

Furthermore, the need for consistency was spoken of at length by numerous participants. They felt this helped to keep the mothers feeling contained, whilst also mirroring what consistency may look like in a relationship.

> *"Not to let them down. So I think they need to feel contained and they need that from knowing that if you've planned to see them Wednesday at 9 o'clock then you'll be there Wednesday at 9 o'clock and if you are unable to do that then you let them know appropriately." (Clare)*

Boundaries was another pertinent area that many participants discussed in relation to working effectively with mothers who have a diagnosis of EUPD.

> *"So yeah, just being quite heart on sleeve and quite vulnerable. I think vulnerability is a massive strength and I think if you can kind of be boundaried but also show your vulnerability and show you've had a story yourself, erm, I think it allows people to open up and be more honest with you." (Elizabeth)*

> *"I suppose making sure you're not disclosing too much about yourself, keeping to times and I would say there does need to be some kind of agreed rule about not attending or cancelling appointments." (Florence)*

However, within the narrative of boundaries, participants acknowledge the dilemma of wanting to maintain boundaries but feeling unable to do so, for a number of reasons. Kendall considers this dilemma in relation to risk.

> *"So I suppose in hindsight when I think about the lady I've been speaking about the most, should I have been as available is questionable but I couldn't sit with myself not knowing if she was ok. So you know the way that I did it was more of a I'll delay but I'll still contact her that day. Erm, so that I can be sure that she had everything she needed before I finish because yeah, that feels like a hell of a responsibility to hold sometimes. So that's been my biggest struggle and remains my biggest struggle." (Kendall)*

When thinking about how these relationships are developed, many participants recognized that the perinatal model allows them to spend time building relationships. Namely, through the use of reduced caseloads in order to build a greater connection with each service user.

> *"When I've worked in community mental health teams before it's been very different, the wards have been very different and I wonder about whether that's a beauty we have of working in a specialist service where you are able to spend a lot more time with people and develop a little bit more of an understanding about where they've come from and I think also because we're a specialist service we can also have, well the hope is, we can have slightly reduced caseloads because of the more intensive work that we do." (India)*

3.6.2 Using an Attachment Focused Lens

Within their relationships with service users, participants discussed how they weave attachment focused principles into their work. Nearly all participants recognised that for women with a diagnosis of EUPD, becoming a parent can ignite memories of childhood trauma and/or relational difficulties. For example, India says:

> *"Sometimes the first time we get people is when they've had a baby and they're not managing and they have no understanding of where this is coming from. And I wonder about how, I'm just thinking about the 'ghosts in the nursery' and how that gets presented to them all of a sudden as they're first-time mums and it's like 'woah where has this come from' because they thought they'd got over something or they've managed something and it isn't an issue anymore but actually it's sitting there somewhere." (India)*

Participants felt that by being aware of these difficulties, it then allows them to help service users gain a deeper understanding of their attachment styles, in order to help them move forward in new relationships, specifically with their babies.

> *"I think most, most people will talk about it on quite a superficial level like especially if they've had significant trauma with their parents or anything like that they will recognise that that's had an impact on them, erm, but may not then always make the link between that and, they'll recognise that as a reason for their difficulties and certain symptoms but may not recognise the extent to how it kind of governs their interactions with other people and how it might affect their patterns with baby." (Eden)*

Additionally, many participants seemed to describe the ways in which they engage mothers in the process of reflective parenting. Their goal within this work was to improve the bond between mother and baby.

> *"You want to prepare them to keep the baby in mind, to keep this child in mind, because you know it's not just an extension of them. This little person is a little thinking and feeling person which needs to be understood." (Savannah)*

> *"But also being able to understand about putting their needs aside and being able to see things from baby's needs, and the child's perspective and because of growing up within*

> *invalidating environments they really struggle with having their voices heard and being validated and having their needs met." (Sydney)*

In addition to this, Chelsea touches on the complexities of helping with reflective parenting for women who have low confidence and self-esteem, which seems to be deeply rooted in how women with an EUPD diagnosis view their identity.

> *"Often you see people with EUPD that have very little support around them, they're not very trusting. And they don't trust themselves with their baby either. They don't trust that they can be good mums and if that is reflected to them by their partner who says one comment, they're trying their absolute best but they fundamentally believe that so you know they have such little self-worth that they don't really see that changing and that's the work but that's a big piece of work." (Chelsea)*

A large majority of participants also acknowledged that the work with mothers diagnosed with EUPD seems to go well because the mothers want things to change for the sake of their children. They speak specifically of the perinatal period fostering a sense of hopefulness, which participants are then able to draw upon within their work.

> *"There is something about the perinatal period that is different. Not for everyone obviously, but yeah I think it instils a different sense of hope and the possibility of change because so much change is happening." (Kendall)*

> *"I think for many of these women we find that they're [...] one of the reasons why I think we are able to have success is because so many women come in and say 'I want this to be different. I want this to be different to how I was parented, how I was brought up, I don't want to repeat what my experiences were' and we call it the window of opportunity." (Charlotte)*

Nonetheless, the idea that mothers have to ‘change’ or ‘fix’ themselves for the sake of their child echoes the aforementioned discussion around greater responsibility for mothers than fathers and how this can be reinforced by social discourses.

3.7 Theme Three: The Fit between Staff and Service

The above theme discussed participants’ views of building effective relationships with their service users. Theme three takes this a step further and summarizes the driving forces behind participants’ abilities to engage in this work. They acknowledge that immersing themselves in relationships on a daily basis is taxing and they have to bring their optimum self to work in order to achieve benefits for the mothers. It also explores the reasons why participants felt drawn to work in a perinatal service and the shared traits that many participants feel they have. Two sub-themes emerged: What Do I Bring to the Work? and Acknowledging the Team Identities**.**

3.7.1 What Do I Bring to the Work?

Within this sub-theme, the notion of self-reflection is evident throughout. Participants spoke of a need, both within themselves and from a managerial level, to reflect on how the work with mothers who have a diagnosis of EUPD makes them feel. Participants felt that a key area within this reflection was to separate their own emotions from the mother’s emotions. India and Charlotte are from two differing professional backgrounds, a nurse and a psychologist respectively, yet the awareness of reflection is apparent in both accounts.

> *“I think it’s about for me identifying where those feelings are coming from and noticing if it comes from the patient and it’s being placed onto you but kind of misplaced in a way. Erm so I think just doing that sometimes can be really helpful but when you’re in it it’s really hard you sometimes need somebody to do it for you.”* (India)

> *"I think also being able to name but in a safe way what we bring to the party as well. So you know the reactions and erm behaviours of our, of our, our mums and families come in the context of a relationship, so we bring stuff. So how do we name that safely without that bordering on becoming their own therapy but saying actually I know I can activate people in a way because how I'm feeling today. And that being ok to speak about. That's something that's not spoken about whether it's in adult mental health or specialist services enough."* (Charlotte)

Charlotte is seemingly reflecting on how although it is important to reflect on your inner experiences, there is something about bringing own emotions to work conversations which requires careful judgment and does not always feel possible. It appears that speaking about your lived experience as a staff members goes against the status-quo of the team's dynamic.

Additionally, participants felt it was important to name any transference that may happen within a relationship with a service user, particularly any maternal transference. Clare exemplifies this below and discusses her reactions to this process.

> *"We used to have reflective practice with the lead psychotherapist when I started the job and I was talking about one of my ladies once and he said 'but you're her mother' and I was absolutely taken aback when he said that and I said 'I am not, I do not want to be her mother, I am not her mother'. But you are, you are almost like their foster mothers sometimes, where their mothers may not have had the emotional availability for our mums, they may not have a mum, they might have suffered trauma at the result of the mum, whatever the case you are kind of their surrogate mum for a period of time."* (Clare)

When naming and noticing transference, Madeline reflected on this in her role as a psychologist, demonstrating how differing professions can be utilised to help the team.

> *"We offer something called enhanced consultation. So we'll offer consultation with the practitioners and sometimes what we'll do is go out and offer a joint visit with the practitioner and mum and do kind of a bit of formulating in the room [...] Because you come in and you're very separate and you're like 'oh I'm noticing this thing happening between the two of you, I'm wondering if this is going on?'. And it gives the practitioner, it means the practitioner hasn't had to say because sometimes they feel like they don't have the skills or the confidence to kind of name some of the dynamics in the room, but you've put it on the table and then it gives them kind of the opportunity to go forward with mum." (Madeline)*

At a managerial level, India discusses the implications of staff not reflecting on how they are feeling as a result of the work. It emphasises that they may sit with distress that becomes displaced into system issues. However, India highlights the intricacies of reflection when staff feel like there is not enough time in the day to engage this process.

> *"If they're going from one thing to another like things kind of are at the moment where things are intense I find that staff are feeling, it kind of overspills if you know what I mean. Like 'I've got this parking ticket you've got to sort it out', or 'the milage rates are unacceptable you've got to sort it out', that sort of gets filtered out somehow. But if they've got a little bit more time and space in between clients I think that they're able to see where this distress is coming from." (India)*

On a very significant note, a number of participants spoke of the increased risk of burnout working in the perinatal service and how if they are not consistently checking in with their own emotions then the likelihood of burnout increases. Thus, many participants spoke of a greater need for self-care and how they have to work hard to look after their own mental health.

> *"So I think I'm in a bit of another learning phase. So I'll do lots of self-care type things outside of work to the best of my ability but I do find that sometimes I'm not capable and that's when I start to say to my management something is going to have to shift here." (Kendall)*

Both Morgan and Kendall reflect on their professional identity in relation to self-care, interestingly they seem to express views at opposite ends of the spectrum.

> *"I come from a children's social work background as well so my thing is that actually you must take care of yourself because if you're not well enough then you can't take care or treat someone else either." (Morgan)*

> *"And I don't know whether this is just a nursing practitioner kind of thing but we're really good at preaching stuff that we don't practise for ourselves." (Kendall)*

Clare reflects from her role as manager and having to advocate to staff to attend supportive spaces in order to discuss their own mental health.

> *"But also there's been staff in the team that have had vicarious trauma, secondary trauma, from some of the mums that they've worked with. So we've always been encouraged to have self-care and adequate support, supervision, so I just think yeah I think we're very hot on that. We're very encouraging of that and we value it so much." (Clare)*

3.7.2 Acknowledging the Team Identities

The previous sub-theme was largely participants reflecting on their individual emotions and how this impacts their work. The current sub-theme now presents a collective reflection of the common traits held by perinatal staff and participants' beliefs about why they have been drawn to perinatal work.

Firstly, an overwhelming number of participants discussed the unique maternal culture that is often found in perinatal services. Whilst caring for mothers, participants felt that they themselves take on a maternal role.

> *"I think the other thing as well which I've noticed and discussed in supervision is that the women that come in, and it is often women in perinatal, you find that they're all quite maternal people and I suppose that's the nature of the job is that you want to help others but they mostly come along with a mothering instinct but you know what I mean. Generally people care." (India)*

> *"I think for me it's, it's as I said earlier, it's thinking dynamically, it's the mirroring of the maternal experience. It activates maternal care, erm, I think, you know, people who come into the service for lots of different reasons will want to bring that too, you know." (Charlotte)*

When participants were asked where they think this maternal culture has originated, a number of them felt it was due to the recruitment process.

> *"I think they're [management] really good at recruiting people with a very empathic, compassionate perspective that are really warm. So I think it's something about who we're recruiting and who's interested in perinatal work as it's very specialist and very different." (Sydney)*

Interestingly, many participants then used the words 'perfectionists' and 'rescuers' to both describe themselves and colleagues within their teams. Participants spoke about how these two traits can help them give beneficial care to their service users rather than viewing it with negative connotations, which these words can sometimes be associated with.

> *"As a whole what the kind of people that come to perinatal and particularly the kind of people that stay in perinatal are absolutely these kind of like incredibly compassionate,*

> *you know highly maternal, erm, perfectionistic rescuers and I think there's something about an interplay between the staff being like that and the service." (Madeline)*

> *"I think it's we're just sort of team I don't know if it's healthy or not but we go above and beyond. Just wanting to rescue quite a bit." (Alberta)*

However, some participants did note that by having the trait of perfectionism it can be a detriment to themselves as they try to achieve unobtainable goals.

> *"There are a lot, a lot, a lot of perfectionists or a lot of people who want to offer perfect care and so when they go to supervision and say I can't fit all of this in where do I cut? What do I do? What do I not go to? And they get told, you know, see this mum a bit less or do this by video they're like 'oh my god I can't bear that. I can't sacrifice mum I can only sacrifice me'." (Madeline)*

> *"And I suppose for me I know that I'm a, erm, overly critical, erm, wanting to do the best for people type of practitioner that means that I probably over think stuff but I just want to make sure that I'm doing it right for that person" (Kendall)*

Taking this thread a step further, Madeline spoke of the staff teams reflecting the dynamics of their service users.

> *"I think it does happen in other services as well that services tend to reflect the dynamics of their patient group you know and the kinds of, so of course we've got across the board lots of different mums who come through our door but the mums who struggle the most regardless of diagnosis are mums who come with rigidity, perfectionism, control erm issues because babies can't be controlled, hugely uncertain, you never know if you're doing a good job, you never get feedback, you can't wait until they're toddlers then you give them the wrong kind of cup and you've done the worst thing, so there's no way to*

> *ever tell if you're doing a good job and so I think there's something about all of those threads we're mirroring the dynamics of it happening in our patient group." (Madeline)*

Additionally, Sydney felt that there is a certain culture within perinatal services which you know if you will fit in to.

> *"People that have come into the team that don't have quite the same approach very quickly leave which is absolutely fine. I think it is one of those things that because it is very different and very specialist they have to test it out. So yeah some people they just feel it's not the right thing and that's absolutely fine." (Sydney)*

From participants' accounts within this subtheme, the notion of needing to provide 'more than good enough care' seems to be prevalent. As referenced by Sydney, it seems if you are unable to continually provide this more than good enough care, which is ultimately unobtainable, then you leave. This would be important to recognise in teams where burnout is a possibility.

3.8 Theme Four: The Importance of Feeling Valued

This theme illustrates where participants place value in their work. When discussing service users who have a diagnosis of EUPD, participants named a joy within the work and discuss the factors that help to keep them feeling motivated. As such three sub-themes have been crafted: Reciprocal Appreciation, Leading by Example and Feeling Part of a Team.

3.8.1 Reciprocal Appreciation

The first sub-theme was created to incorporate participants' expressions of gratitude towards their clients with a diagnosis for EUPD. This is notable given that clients with this diagnosis are often described in the opposite way. In particular, Elizabeth explains what she has personally gained from her work with these women.

> *"You learn so much from this cohort of women. Erm, they've often got real personalities. Real sort of fun-loving characters underneath. Like there's a lot of, there's so much strength in them, so much resilience in them, erm, you're definitely kept on your toes a lot of the time. They teach you a lot about yourself, definitely teach you a lot about yourself." (Elizabeth)*

> *"By the time I did discharge her she was still self-harming, she was still doing things that weren't helpful, um, but actually she was in a much better place and you could see the resilience starting to shine through from her again. So yeah, it's just amazing working with these women." (Morgan)*

Additionally, Elizabeth went on to describe feeling appreciated by her client, which came as a surprise to her.

> *"I said to her 'what are you going to take from our work together' and I thought she was going to be like 'ah nothing really I'll just miss having a coffee with you' or something but she said something about how, erm, she was like 'you've taught me what a relationship should be like' […] I still carry her everywhere, my keyrings not here but when I discharged her she got me this keyring, erm, it was very sweet. It's on my keys I think it says like be proud of the work you do every day. Very special. I remember getting it and being like 'what!'. I was really shocked." (Elizabeth)*

Alberta reflects on staff going above and beyond their job role because staff are able to build such a rapport with their service users and want to do the best by them.

> *"One thing that I think is that everybody works more than they're supposed to and that's not good but, erm, I think it's just people are so able to build that rapport that they just want to help and feel like they need to. And maybe it's something to do with the clients, the clients are often very lovely so, yeah." (Alberta)*

3.8.2 Leading by Example

Leading by Example portrays the majority of participants' gratitude for their management. They ultimately felt that they are able to work effectively with mothers who have a diagnosis of EUPD because of the overall support they receive from management. One way this was described was by management being available. As such, participants felt able to contact them whenever needed but also be open about when they were struggling with a piece of work.

> *"So our senior managers are amazing. Erm so I could phone them, that normally just doesn't happen you're normally blocked from those people. Erm, and yeah I think that's filtered down to the band 7's and the band 7's filter that down to us." (Kendall)*

> *"I've certainly had times where I've been really distressed about what I've heard in an assessment and my managers have gone 'it's fine we'll take the rest of your cases today, go and have a rest, do whatever you need to do, we'll manage between us'. The support is amazing I literally cannot fault it." (Sydney)*

From a manager's perspective, India spoke of putting practices in place so that staff know how to contact a manager if required. She alludes to providing containment to staff.

> *"We have a CLOD rota as well so that's a clinical lead on duty and quite often I'll get a call from somebody saying this has happened and quite often they don't need an answer they just want to tell you what's happened and they just want a bit of a virtual hug to be told that sounds really hard but you've done everything you can, a bit of reassurance. So that can be quite useful." (India)*

> *"The other thing I get is people copy me in emails. So I've asked them to copy me in if they're worried about something so that I've read it. Sometimes I won't reply and sometimes I will reply to them and say 'oh have you thought about this, or that's a great*

> *email' but I think that shares the burden a little bit that there's someone else aware of it." (India)*

Furthermore, many participants appreciated the lack of imposed hierarchy in regard to their management. They spoke of not feeling inferior to managers and how management often get involved with daily tasks, which may not always be considered to be a managerial duty.

> *"So just knowing that she's there when I'm feeling overwhelmed is great and I don't know many managers that would do duty, that would sit in and pick up tasks and triage people and respond to urgent tasks, like it's just done. We all sit in duty to help out and keep an eye on it." (Chelsea)*

Chelsea seemingly describes here her feelings of containment which is provided by management. This relational management approach seems to offer containment to staff who are seeking to provide the containment that mothers may need to contain their children.

Furthermore, participants spoke of how management advocate for a culture of reflection within their teams, namely through reflective practice attendance.

> *"I think our management are very reflective, (service manager) is very reflective and open to discussion and I think that is filtered down through the service most definitely. And having (psychologist) at a lot of our meetings as well is brilliant because she'll often stop things and make sure we're taking other things on board as well." (Clare)*

Managers also shared this perspective, specifically to help with staff wellbeing, as evidenced by Clare. She is able to reflect on her own experiences within the team and how she has been personally impacted by the work.

> *"As soon as staff start in the team I say to them make sure you're getting clinical supervision, make sure you're attending the sessions, because it might not happen straight away, and it didn't for me, six months down the line I took a phone call and boom. I'd heard all this information from a mum and I thought this is what everyone was talking about. When I had that call from a mum who had sexual trauma, hearing it all." (Clare)*

However, a psychologist acknowledged the tension between the service advocating for reflective spaces to help clinical practice but staff not having enough time to attend.

> *"In our service our team leads and our service managers will definitely value reflective practice but I think the nurses they feel like they can't because they're like actually I didn't have a lunch break any day this week or I worked an extra three hours every day this week I can't spend an hour and a half thinking, you know, unless you're going to give me an answer at the end of it which of course most of the time we won't do." (Madeline)*

3.8.3 Feeling Part of a Team

From the majority of participants' accounts, there was a felt sense of containment and safety within their respective teams. This sub-theme illustrates the ways in which this feeling has been achieved and how they feel they utilise team relationships to ultimately improve their clinical work with mothers who have a diagnosis of EUPD.

Many participants spoke of the high-risk behaviours that can commonly occur when working with this group of women and how a multi-disciplinary team approach helps them to regularly hold risk. Kendall alludes to not feeling alone.

> *"The team that I'm in now everybody is super helpful, super understanding, willing, engaging and supportive in any sort of way that you need. Erm and so yeah, it does help because this job is really tough at times, erm, and so for example I'm working with a very*

> *complex case at the moment and I've been able to speak to a social worker, safeguarding supervisor, the managers." (Kendall)*

Within the thread of not feeling alone, some participants spoke of how the team help professionally but also personally. There is a sense that participants have built connections which run deeper than just work colleagues, as is illustrated by Chelsea with the use of her word 'friends' within her account.

> *"And I know that if I was to say I was struggling, as I have done, my friends would be like 'well I'll come and do a joint visit with you, I'll come and sit in on it, I'll see her if you want'. I've picked up somebodies caseload when they were on leave, we just do it. I don't want to see anybody go without or struggle, erm, so there's that kind of informal process or just sort of relying on your colleagues or just going 'guys I don't know what's going on with this, what do you think I should do?'" (Chelsea)*

> *"But I think also on a personal level it's the really good support and empathy we have for each other and anyone in the team would do anything for anyone so it's really lovely and really supportive." (Sydney)*

Furthermore, participants demonstrated how honesty can prevail because of the team culture that has been created.

> *"I think it's made to feel quite a comfortable environment where people can sort of speak and generally be heard. It's not the sort of environment where you're afraid to say something wrong so much."(Alberta)*

However, Chelsea captures the double-bind that can be felt when you work in a team which you feel passionate about. As such, there is a perception of pressure that is placed onto her. Her quote also alludes to the aforementioned perfectionist tendencies of staff who work in perinatal services and the emerging narrative of having to provide ‘more than good enough’ care.

> *“You want to bring your best self for the service because you don’t want, or I feel like I don’t want to be the weak link.” (Chelsea)*

3.9 Theme Five: Trying to Navigate a Complex System

The above theme explored participants’ feelings of value and how this impacts their work. However, the current theme will now present the dilemmas which participants felt they face when trying to navigate their way through an NHS perinatal service, in regard to working with women who have a diagnosis of EUPD. Two sub-themes will be explored: The Constraints of Time and Having to be a Jack-of-all-trades.

3.9.1 The Constraints of Time

This sub-theme identifies the ways in which participants felt ‘time’ impacted their working capabilities, for women who have a diagnosis of EUPD. Time is explored in the literal sense but also the ‘felt sense’ and how participants believe this impacts their wellbeing.

A pertinent area which was discussed within this sub-theme is how participants did not expect to work with such high numbers of women who may have an EUPD diagnosis within the perinatal service. This is summarised by Charlotte who reflects on why this need may have arisen.

> *“They did an audit, it’s a while back now, but they found it was 60% of the caseloads were meeting that sort of threshold I guess for complex need but that’s not surprising I think it’s, you know, if you think about an adult mental health that’s predominately of people with complex need and so why would perinatal be any different because they’re getting pregnant that’s 50% of the population can embark on that journey whether they are then*

> *able to have the child is a different matter but thinking about that, so statistically we are going to see you know a number of women with complex need." (Charlotte)*

The combination of caseloads holding a large number of women who are likely to have extensive need and a lack of staff resources was discussed by Clare, who considers how this can impact service user treatment. Similarly, it evidences how practitioners are a finite resource which only certain service users can access.

> *"And the resources at the moment might mean that that [treatment] period is shorter than we would want it to be because we haven't got enough practitioners to work with mums from conception through to one year post-natal. We haven't got that luxury really at the moment." (Clare)*

The impact of time on treatment was also discussed within the context of psychological therapy. There appeared to be a tension between some nursing practitioners believing that service users should be offered greater amounts of psychological therapy compared to a psychologist participant reflecting on why this may not be possible. These two opposing views can be seen below; notably by two participants from separate perinatal services, suggesting this tension is occurring in multiple teams.

> *"I suppose in some respects we've talked about this before in our team because in our team we don't offer trauma therapy. We will do in the future but we don't at the moment and when I say but we need to I get 'well you're going to open a big can of worms, if you do that we'll be inundated' and I'm like 'well yeah I know!'" (Morgan)*

> *"We can't always offer trauma work because it's long term, that's not our bag and there's not enough safety and stability often." (Madeline)*

Aside from how time impacts service user treatment, many participants discussed the impact of time constraints on their own wellbeing. There is a sense of having to over-exert oneself to meet the imposed needs of the service. As such, it appears there is a risk of burnout.

> *"I suppose in perinatal you've also got that additionally responsibility about the risk to baby as well. So that gives an extra layer of it being really intense and a real sense of responsibility that it's not just keeping mum safe it's also the unborn baby or children as well so yeah that is emotionally draining. So of course there are times when you're not finishing work on time or you're having to work late or do things on your days off because you want to make sure everything is in place and risk plans are done, so yeah I suppose it's very challenging I would say." (Sydney)*

> *"And we're all so busy when you talk to the clinicians they literally have got the time to do the assessment quickly, write up the letter and then it's gone." (Morgan)*

3.9.2 Having to be a Jack-of-all-trades

This sub-theme will now explore how participants felt their role is ever-changing and a general sense of not having guidance to follow, in relation to working with mothers who have a diagnosis of EUPD.

Several participants felt unable to define the work that they complete with this client group and the implications this can have when trying to measure practical change with your service users. For example:

> *"Because if you asked me what piece of work is done with that lady in technical terms I couldn't tell you. I literally couldn't tell you. I probably done all kinds of different things. Erm, you know she was not in the kind of place where you do a structured piece of work and most of these women aren't sadly, they're just not. Erm, so a lot of it is just compassionate listening, erm, and yeah just yeah just trying to be present with them really." (Elizabeth)*

> *"So I think in terms of the work we're doing with them I think it is about, I find measuring the work we do; what actually is that we do that is beneficial? Because it's very hard to measure that [...] because I think there's always something about whether will the work you do together, because it's very hard to articulate what you do, will it be sustained in any way?" (Savannah)*

Simultaneously, as participants felt like the work cannot be defined, they also felt like their role could not be defined which is illustrated here by India.

> *"Whereas I think it's almost in a specialist role you're a little bit of a nurse, a little bit of an OT [occupational therapist], a little bit of a psychologist, a little bit of a social worker. All of those little things, you're a blend and you're never going to go in and just do something." (India)*

Eden then narrates what it can feel like on a personal level for practitioners who feel uncertain of their role. She also mentions the impact of time, highlighting the interconnectedness between this sub-theme and the sub-theme above.

> *"You do feel a little bit, useless is too strong of a word, but you feel like 'oh maybe I should be able to actually do a bit more with you, maybe I should be finding the time to use these tools or spend a bit more time on them' but then you've just got so many other pressures. And you don't want to do damage by doing something badly." (Eden)*

Taking a systemic view on this topic, Charlotte discussed why she thinks the role feels undefined for staff members. Specifically, she speaks of the perinatal model design and how this perpetuates a need for staff to work across multiple different presentations, meaning they are unable to focus on one particular client group.

> *"Because the model isn't designed to offer that, you know we're a service that takes in all need at a secondary care level. So you know we've got a number of women with say for*

> *example birth trauma but not complex need, we've got the OCD [Obsessive-compulsive Disorder], we've got the post-natal depression, so as a work force we've got to be across a number of things and I think it's, whilst it, you could argue it's funding but we know we're never going to get all of the funding we need, but what we could say is ok we're going to take the workforce and just concentrate on this. But then what do we give the others? So that for me is the tension." (Charlotte)*

3.10 Theme Six: Where does the Responsibility Lie?

The final theme reflects participants' views of systemic and service issues which they feel impacts their ability to work with women who have a diagnosis of EUPD. The majority of participants described numerous service level issues which they felt are specific to this client group. Two sub-themes were crafted: The Domino Effect and The Invisible Women.

3.10.1 The Domino Effect

This sub-theme explores the impact on perinatal mental health services when participants felt there are flaws in how other community mental health teams (CMHTs) operate. Many participants felt that CMHTs refer pregnant women who have a diagnosis of EUPD into perinatal, not necessarily because they need help, but because they are unsure of how to 'hold' these women. For example:

> *"I think that we see a lot more of this diagnosis because general mental health services don't know how to deal with them so as soon as they're pregnant they're like 'ok perinatal can have them because they can help out'. So I do think it's a failing of other services that our caseload is so high." (Chelsea)*

> *"I think our service kind of women coming in and being like I don't know what to do, we just don't know what to do, we don't even really know why they've been referred to us,*

> *they've just been referred to us because they're pregnant but there's nothing perinatal about this presentation as in it hasn't started in the perinatal period, it's not been made more acute by the perinatal period, there's nothing you know perinatal about it she just also happens to be pregnant and have babies." (Madeline)*

Continuing with this thread, Madeline explains her belief as to why perinatal caseloads are predominantly women with this diagnosis as a consequence of over-stretched CMHTs. She takes this further by discussing the impact on clients' care.

> *"I would say with EUPD diagnoses I would say that's probably the bulk of where it sits where we can't get them back in to CMHT once we've done our work and they're just waiting. They're just sitting on our caseload, we're ready to discharge them but we don't want to discharge them to nothing, we don't want to discharge them back to primary care because it's not appropriate but CMHT won't take them." (Madeline)*

Similarly, Clare discusses how perinatal services are holding women with a diagnosis of EUPD for longer than they should be as they cannot discharge them without adequate care provision, but the perinatal need has now subsided. She questions how the diagnosis itself may have an impact on this process.

> *"Also it just takes so long to discharge some people because you have to wait for decisions or then they make a decision and they haven't put anything in place and then you have to try and pursue and challenge that. It's very, very tricky and I think the diagnosis is read before anything else on the referral unfortunately and that's very unhelpful in some teams." (Clare)*

Furthermore, the decision to discharge a mother knowing there may be no ongoing care weighs heavily for staff who have put time and effort into helping these women whilst they have been under the perinatal service.

> *"What would be great is when you discharge someone knowing they're actually going to get adequate mental health support elsewhere but erm I think one of the hardest things is discharging someone knowing realistically they're not going to get to see anyone." (Elizabeth)*

Moreover, Madeline discusses how CMHTs view the perinatal service in regard to their service provision:

> *"What CMHT has said to us before is, erm, basically that we've set them up to fail because they can't possibly offer anything similar to what we offer and they're kind of like, you're basically I think not in so many words, your care is good that mums can only be disappointed when they come back to us, we're like well we can't offer less than what we offer just because you can't offer the same thing. We do work on expectation management but we have lots of mums who just sit in that gap then and we can't get them back into CMHT." (Madeline)*

Due to the aforementioned challenges, participants discussed how they are trying to overcome these difficulties by taking initiative to educate CMHTs on the boundaries of perinatal provision.

> *"In our service we've tried to do a lot of work on educating the CMHT about our role and how it's different and that we're not a CMHT and that we don't have crisis resources or do care coordination but it's a bit of an uphill battle to be honest." (Eden)*

Similarly, several participants recognised that the mothers cannot fully engage in perinatal work because they need support for their social system but no services exist to help with these challenges.

> *"Having the opportunity to do the graded exposure while they I don't know have their children cared for by a child minder because they're struggling to do it all. So breaking,*

> *so allowing them time to do this work, I know they can't because they're mothers and they always have their children with them but that can be a barrier too because you don't want to talk about something really emotive when you're trying to care for a screaming baby erm that can get in the way of the work." (Chelsea)*

3.10.2 The Invisible Women

The invisible women sub-theme portrays the overwhelming narrative that mothers who have a diagnosis of EUPD seem to have been 'forgotten' about, in service design and mental health systems more broadly.

Firstly, participants recognised that for a lot of women on their caseload this is the first time they have come to the attention of services, meaning they have had to deal with their difficulties alone. This is not to say that they have not been managing well but participants spoke of examples where they feel care should have been provided earlier for the woman's wellbeing.

> *"We have women where they've never reached that threshold for secondary mental health but they come into our team and we hear about all of the trauma that they have been through and thought oh my goodness, you know [...]. We've found that for years. Because they've never reached the threshold because it's so much higher in adult mental health than it is in perinatal." (Clare)*

Additionally, Madeline spoke of perinatal mental health funding and the consequences this has had on service provision for women with this diagnosis. They had, in essence, become forgotten about when planning for perinatal need.

> *"When our service was funded [...] they looked at numbers and they said this is how many women you'll have with SMI (serious mental illness) diagnosis, we'd expect this amount of profiles for women, duh duh duh duh, so all sorts of things from erm postpartum*

> *psychosis, bipolar 1 and 2, postnatal depression, general anxiety catch all, erm and so we're going to fund services based on these kind of numbers. It didn't include complex trauma slash EUPD at all and then within six months of starting the service we were saying our caseload is 60% women with this diagnosis and we're not funded at all to kind of meet this need." (Madeline)*

As such, numerous participants discussed the impact of funding on the types of treatment they would like to offer women with this diagnosis but are unable to due to service constraints or a lack of resource. Eden captures the complexities of this dilemma, especially with reference to the pattern of symptomology profiles these women may exhibit in the perinatal period.

> *"But at the same time it's really challenging because of the treatments that are offered for personality disorders they tend to be really, really intensive. The mums can't access them with their babies, there's no provision for this. They often have, erm, some of referral criteria is that they have to be frequently suicidal or frequently self-harming and for a lot of mums I find that this goes down a lot in pregnancy and when they've got a young child cause they've just got that different level of responsibility so that's difficult." (Eden)*

> *"That's part of our trickiness because as a service we still think what do we offer mums with complex trauma, what's our offer? [...] We can't offer a full-on DBT programme because we're not staffed or resourced for that." (Madeline)*

Charlotte feels that the answer to the lack of treatment options for these women would be to create services specifically designed for their need. Within her account she refers to the notion of the perinatal model having to meet multiple types of need, as previously discussed by other participants within the Jack-of-all-trade sub-theme, but speaks about how it could be overcome.

> *“Well I would love to offer a service that just really works for these women. Because I think I think one of the trickiness of the model, the perinatal model, is that it’s designed to be a jack of all trades. I think one of the things we’ve struggled with is how do we be available to all of these different presenting needs. And I think in my ideal I would like to sort of proportion some of the service as a dedicated service. Um, because what we’re not able to offer are the treatments that are most effective. So for example offering a full DBT programme or a full MBT (mentalisation based therapy) programme um you know we’re having to offer things that are informed and whilst it’s something we know it’s not it’s not good enough.” (Charlotte)*

3.11 Conclusion

Overall, the results of the current study have highlighted numerous ways in which perinatal mental health staff work effectively with mothers diagnosed with EUPD, within the context of current perinatal service provision. Namely, participants have reflected on the importance of relationally based work with this client group and the tendency this has to make them feel like ‘better than average’ care is required. They discussed the risk of burnout that can arise from this way of working and the challenges they face in the absence of other community service involvement when working with mothers diagnosed with EUPD. Many similarities are evident between the results of the current study and the results of the literature review outlined in chapter one.

Discussion

4.0 Chapter Summary

Within this chapter, the results of the current study will be summarised. Then, the strengths and limitations as well as the clinical implications and recommendations of this research will be discussed. Finally, the chapter will conclude with a reflexive statement from the researcher in regard to their learning. The interpretations made within this chapter are both semantic and latent in nature and they are informed by the research epistemology, theories discussed in the introductory chapter and the researcher's positionality.

4.1 Summary of Findings

The current study is, to the best of the researcher's knowledge, the first in the UK to explore perinatal mental health staff experiences of working effectively with mothers diagnosed with EUPD. Much of the existing literature has investigated mental health outcomes for children of mothers with a diagnosis of EUPD, in comparison to the mothers themselves. Therefore, this study offers an original contribution to the knowledge base by giving insight into what is effective for these mothers during the perinatal period, from a clinician's perspective. Thirteen participants from three perinatal mental health services in England participated in the research. Using reflexive thematic analysis, six main themes and 13 sub-themes were identified. Contextual interpretations of each theme will now be discussed.

4.1.1 Theme One: Let's Talk About Labels

This theme illustrates participants' insights into diagnostic labelling and how they feel it can directly and indirectly impact mothers with a personality disorder diagnosis. Within this theme there were three sub-themes: *Advocation for Complex Trauma*, *Medical Model Critique* and *Recognizing Intersectionality*.

The sub-themes *'Advocation for Complex Trauma'* and *'Medical Model Critique'* appear as a by-product of each other, in that by advocating for the term complex trauma instead of personality disorder, participants tend to question medical model diagnoses. This may suggest some identification between staff and service users, as they too reject the EUPD label on behalf of the service user. As discussed in chapter one, it is known that personality disorder labels are contested (Campbell et al., 2020; Raven et al., 2009) and can lead to high levels of stigmatisation from health services. This has recently been illustrated by Masland and Null (2022) who discovered that staff reacted with greater levels of anger and blame to service users with a personality disorder diagnosis than those diagnosed with schizophrenia. It can also be said that the stigmatisation of those with an EUPD diagnosis, specifically mothers, may be prevalent in social care services. In a sample of 46 mothers who were undergoing care proceedings for possible separation from their child, 13 met criteria for an EUPD diagnosis and 18 presented with 'strong features' (Laulik et al., 2016). A clinical recommendation of this research was that mental health services should place mothers who have an EUPD diagnosis on an 'at risk' register. Whilst they state this would lead to more timely intervention from social care, it could be regarded as persecutory in nature to assume that all mothers diagnosed with EUPD are a risk to their children. For the current participants, then, to openly critique the perceived overuse of personality disorder diagnoses in UK mental health settings sits in stark contrast to much of the literature surrounding this topic. This aversion to the dominant narrative was expressed by participants from differing services, suggesting that conversations concerning the efficacy of personality disorder diagnoses is happening across localities. Participants considered complex trauma to be more developmentally grounded and beneficial as they felt it captured the essence of an individual’s difficulties in the context of trauma, rather than a judgment of their personality. These views are in line with the trauma informed approaches discussed in chapter one. Participants were not suggesting to disregard a medical model approach entirely but rather modify elements which they felt were negatively impacting service users. These views could be considered somewhat controversial for NHS perinatal staff to express, given that perinatal service commissioning is largely influenced by the Royal College of Psychiatry. The Joint Commissioning Panel for Mental Health (JCP-MH) is a collaboration co-chaired by the Royal College of General Practitioners and the Royal College of Psychiatrists, which created the Guidance for Perinatal Mental Health Commissioning in November 2012. The guidance aims to “assist specialised commissioners [of perinatal services], as well as Clinical Commissioning Groups and Health and Wellbeing Boards. It will also be of use to provider organisations, service users, patients, carers, and the voluntary sector” (JCP-MH, 2012, p. 4). Given that RCPsych is involved in perinatal commissioning, it is understandable that perinatal mental health services would adhere to a medical model of mental health diagnoses in the UK. However, participants’ narratives suggest that they feel able to question the effectiveness of such diagnoses within their teams.

The questioning of EUPD diagnoses has also been addressed in the ‘Good Practice Guide to Support Implementation of Trauma-informed Care in the Perinatal Period’ (NHS England, 2021). The guidance was created for all staff working in perinatal services in England to showcase trauma informed initiatives. Trauma informed approaches seek to create systems and services which are grounded in complete understanding of how trauma can impact an individual as well as engendering safety and trust whilst avoiding iatrogenic harm and re-traumatisation (Sweeney et al., 2016). The fact that NHS England are advocating for trauma informed care is promising, although it could be said that at times the use of contradictory policies, for example using the ICD to diagnose individuals and then advocation for trauma informed initiatives, illustrates some unresolved tension between psychiatry led approaches and psychologically informed approaches. Nonetheless, within this guidance the EUPD label is discussed: “It is increasingly acknowledged that the behaviours associated with ‘labels’ of ‘personality disorder’ may represent patterns of learned behaviour that developed as a consequence of prior experiences, as such, many find the use of these diagnoses unhelpful” (NHS England, 2021, p. 9). Whilst no participants discussed this guidance within their interviews and as such it cannot be ascertained whether they have seen it, what they discussed in relation to labelling corresponds well. Additionally, the document outlines four areas of trauma informed care which should be fulfilled in perinatal services: Compassion and Recognition, Communication and Collaboration, Consistency and Continuity, Recognising Diversity and Facilitating Recovery. Perhaps unintentionally, the majority of participants appeared to discuss these areas within their interviews, which is reflected within the main themes. This indicates that, to some level, trauma informed care is being implemented implicitly within perinatal services. However, as previously mentioned, it cannot be ascertained whether staff explicitly use this guidance as this was not discussed. Nonetheless, it is a positive indication that service users with personality disorder diagnoses are being considered in trauma informed ways by perinatal mental health staff.

The sub-theme *‘Recognizing Intersectionality’* takes the notion of labelling further than just medical diagnoses by considering the various intersecting social identities that clients diagnosed with EUPD may hold. Within this subtheme, multiple participants considered how an awareness of class and gender can help them to work more effectively with their clients as they are not perpetuating a cycle of stigma. There was, for some participants, a concern expressed that women from lower social class backgrounds appear to be diagnosed with EUPD at greater rates than their middle or upper class counterparts. Importantly, they felt able to question these narratives within their teams. It is possible that participants felt these concerns regarding social status and class as there was some level of identification happening between them and the service user. For example, if a staff member identifies as being from a working class background and they hear comments they disagree with about a service user's social status and/or treatment, this may create a sense of protectiveness and identification between them and the service user. Exploring the notion of EUPD diagnoses and class, Hengartner et al. (2013) found that childhood poverty is associated with higher instances of personality disorder diagnoses in adulthood within a Swedish sample. Yet, participants' narratives suggest that although they feel women who are considered to be from a lower social class are more likely to receive a diagnosis of EUPD, this is due to the combination of their class as well as stigmatisation from services and clinicians. This is because they felt that these women were automatically 'labelled' and not given time to consider alternative diagnoses, such as bipolar, that their middle or upper class counterparts received. These discussions are reminiscent of the feminist critique of EUPD outlined in chapter one, given that participants feel the distress of these women is being responded to differently because of their sex and class. Taylor (2022, p. 44) discusses how women from a lower social class are automatically stereotyped for their worth in society. She asks "how can a middle class person display the exact same behaviours as a poor, working class person and still avoid being sectioned, or having their children removed from their care? The answer is money and social status". This echoes participants' narratives used within this subtheme, highlighting a discourse surrounding classism and EUPD. Aside from health settings, this also appears applicable in social care. Bywaters et al. (2020) found that families under a child protection intervention were more likely to be from a lower social-economic background, as indicated by deprivation in the neighbourhood with which they lived. Additionally, Stokes and Schmidt (2011) identified race and racism as an important factor in child protection cases, with minoritized races being more likely to receive attention from child protection services.

Participants in the current study did not mention race in any aspect of their interviews. This may in part reflect the demographics of the areas in which they work, considering service users are most likely to be white, or that they themselves were mostly white. However, it is important to note the omission of race in a sub-theme regarding intersectionality given that, as previously outlined in chapter one, the MBRRACE-UK report found that women from a racialised background are disproportionately affected by ill health or death during the perinatal period. McKenzie (2019) argues that although the MBRRACE-UK report has done well to highlight the concerning statistics for mothers from a racialised background, further investigations are needed to understand the causal connections leading to these deaths. This further highlights the importance of discussing race and minoritized individuals who access perinatal services within all aspects of perinatal research, where possible.

4.1.2 Theme Two: We're in This Together – The Work is Relational

In summary, this theme explored how participants felt they work effectively with mothers who have an EUPD diagnosis in the context of relational work. Two sub-themes emerged: *Mirroring a Healthy Relationship* and *Using an Attachment Focused Lens*.

In the sub-theme *'Mirroring a Healthy Relationship'*, participants' accounts seemingly describe the balance that is required in order to maintain a relationship with the mothers, whilst not losing their trust. They spoke in an overwhelmingly positive manner about their clients but did note some common dilemmas in the relational work. For example, participants described implementing boundaries versus not being authoritarian, providing consistency versus not being too regimented, giving gentle encouragement versus overwhelming them with advice. It feels there was a 'push and pull' narrative from participants in that they are committed to building a therapeutic relationship with the mothers but they then have to refrain and question whether their actions are appropriate for this client group. An example of this is with boundaries and how participants described the fine line between wanting to be personable and available but not wanting service users to become too dependent. The Claustroagraphobic Dilemma (Rey & Magagna, 1994) explains how clients, usually with an EUPD diagnosis, can feel trapped when involved in a relationship desperate to escape then terrified once free of it seeking retreat to the illusory security of the primal home. As such, they spend much of their lives in transitional states, suspended between feelings of suffocation versus feelings of abandonment. From the participants' accounts in this sub-theme, it could be suggested that they too as staff members allude to a certain element of this dilemma within their work, as they continually express the desire to help versus not making things worse. It seems that they are mindful of not wanting clients to 'abandon' the work whilst making sure they are not 'suffocating' them with support. Consequently, they as staff seem to engage in a continual process of questioning their actions which one could assume would be a tiresome and lonely process. However, participants never described it in this way.

In the second sub-theme *'Using an Attachment Focused Lens'*, nearly all participants discussed how mothers enter the perinatal period with a desire to change for the sake of their child. Thus, they reflected on how the work can feel easier for them to engage in as staff because they have the willingness from mothers who want to improve. Therefore, it seems the issue of the Claustroagraphobic Dilemma may be reduced, as clients are less likely to abandon the work due to their strong desire for change. Notably, the strong desire for change which was discussed by participants may in part be influenced and reinforced by the policies and discourses surrounding parenthood. For example, UK governmental policy states that mothers can take up to 52 weeks of statutory maternity pay, in comparison to two weeks for fathers. By allowing mothers a greater amount of leave than fathers, it reinforces the social discourse that mothers should be the child's primary caregiver, rather than the father. By perinatal services only working with women, it is further promoting the belief that the mother must be the one to 'work' on herself as she holds the greatest responsibility for the child.

Thus, the mothers may express this narrative as they believe this is the socially acceptable thing to do whilst contending with their own, often very serious, mental health needs.

Within both sub-themes, it is important to explore how the aim of this research may have influenced participants' narratives. For example, participants gave positive accounts of their work and spoke very openly about how the relational work can be joyous for all involved. Conflict and challenges within the relationships were not as explicitly mentioned. However, participants did note the types of dilemmas they can often face with this group as a whole. It may be that participants wanted to showcase positive examples as the aim of this research was how they work 'effectively', or it may be possible that naming feelings considered to be 'negative' felt too unsafe. For example, from a psychodynamic perspective, teams engage in certain social defences so as to reduce the level of anxieties that they encounter when working with emotive content. Lyth's (1960) research on nursing staff in a training hospital in London found that they employed a number of defences which kept them detached from the service user. Therefore, the absence of more negative accounts may have a defensive function of enabling participants to continue working despite the distress that may be evoked from intense relational work. Winnicott (1949) coined the term 'hate in the counter-transference' in his paper of the same name. He used the example of a mother and child to argue that mothers have to tolerate feelings of hatred towards their child, which they will inevitably have, without acting on the emotion. He then stated that *"*if an analyst is to analyse psychotics or antisocials he must be able to be so thoroughly aware of the counter-transference that he can sort out and study his objective reactions to the patient. These will include hate" (Winnicott, 1949, p. 350). Van-Wagoner (2000) discusses how therapists should feel able to name feelings of hate in the countertransference with their supervisors, in order to be the most effective for the client. If not, they will end up repressing these feelings which would ultimately impact the therapeutic work (Maltsberfer & Buie, 1947). Applying this concept to motherhood, dominant discourses rarely acknowledge the often profoundly ambivalent and varied feelings evoked by motherhood. They instead tend to idealise the concept of motherhood, which then constrains the range of emotions that women are sanctioned to express (Rose, 2019). For example, if a mother began to openly state annoyance or dissatisfaction at being a mother within an English society, it may be likely that she would receive backlash for such remarks and fear reprisal from services such as social care, given that this is not something that is openly discussed or normalized. Rose (2019, para. 1) discusses how the intention of her book ‘Mothers: an essay on love and cruelty’ was to “give a truer, more virulently exhilarating and disturbing account of motherhood in our general culture. That’s what the book’s trying to do; it’s trying to say, can we put this out there?”. Indeed, therapists may feel these sanctions too if they enter a service where only ‘positive’ feelings can be named. Moore (2012) expresses how there is still a ‘culture’ within personality disorder services whereby it is covertly deemed unprofessional for staff to admit to having personal emotions about clients. Thus, although the narratives in this theme highlight positive examples of client work and this should not be disregarded, it is important to think about what has been left unsaid and why this may be.

4.1.3 Theme Three: The Fit Between Staff and Service

This theme focused on participants’ expressions of how and why they engage in perinatal work and how they are personally impacted by working with mothers diagnosed with EUPD. Two sub-themes were created: *What do I bring to the work?* and *Acknowledging the Team Identities***.**

In the sub-theme *‘What do I bring to the work?’* there appeared a unified narrative of needing to reflect on your own emotions when engaging in relational work. Moreover, there was variation in this topic dependent upon participants’ professional backgrounds. Psychologists referenced how their core training invites them to engage in regular reflective practice, whereas nurses felt they usually neglect this type of work as it would mean prioritising their needs over the clients. However, they recognised that this view is exacerbated by the lack of time they have to complete their daily tasks. As a consequence, numerous participants discussed the risk of burnout when working with moderate to severe perinatal mental health needs. As previously mentioned in chapter one, the NHS Long Term Plan aims that 66,000 women with moderate to severe perinatal mental health difficulties must be able to access care and support in community perinatal teams by 2023/24. Additionally, support will be increased from 12 to 24 months after birth and there should be increased access to psychological therapies (NHS England, 2019). Whilst this is a promising development for women accessing services, given that participants are already expressing feelings of burnout this is a concern if staff retention is not prioritised alongside the increasing number of referrals. From participants' viewpoints, there would need to be greater emphasis on staff feeling able to attend reflective practice from service structure, so that they do not feel like they are taking time out of their typical working day to attend these spaces.

In the sub-theme *'Acknowledging the Team Identities'*, participants reflected heavily on the type of traits they exhibit as perinatal workers and thought about how this influences their effectiveness with clients diagnosed with EUPD. There was consideration of how the staff team tend to reflect the traits exhibited by the mothers they work with as well as traits between each other as staff members. This included the need to rescue, maternal care and perfectionism. The role of a staff 'rescuer' (De Vries, 2013) does not seem to be widely addressed in psychological literature, but the 'wounded healer' narrative, that is someone who has previously or currently experienced mental health difficulties and thus chooses a role where they can help others in a similar position, is more prominent (Conchar & Repper, 2014). Furthermore, there appears to be a lack of evidence into the notion of providing 'maternal care' within services, that was described by participants as taking on a motherly role towards clients whilst remaining boundaried and professional, and whether this is unique to perinatal services. In regard to perfectionism, this has previously been addressed in mental health staff, finding it to be higher than expected in clinical psychology trainees (Grice et al., 2018) and mental health nurses (Henning & Shaw, 1998). As aforementioned in the theme above, in her book, Rose (2019, p. 113) discusses what she considers to be a damaging cliché of ‘perfect motherhood’. The image of “the naturally docile, virtuous and benign mother, who loves her children unconditionally and without restraint” and one who has to live up to perfect expectations set upon her by society. It could be argued that the perfectionism of motherhood mentioned here is what is being mirrored within participants’ accounts of striving to provide perfect care to the mothers they work with. Rose discusses the need for mothers to be able to express the “full emotional range that motherhood entails” arguing against the notion of “hegemonic motherhood” that so often dominates discourse. This resonates with the theme above which discussed how hard it is for mothers, and potentially staff members, to discuss feelings which they may perceive to push against the status-quo. Winnicott (1960) explored the notion of a ‘good enough mother’ arguing that a mother cannot be perfect because she is inevitably her own, flawed person with her own needs. Yet, from participants’ narratives it seems the notion of ‘good enough’ care is being lost due to a desire for perfectionistic care. Where this pressure comes from is unknown but given the systemic influences on mothers to be ‘perfect’ within society, it is understandable why staff working with said mothers may then consciously or unconsciously slip into this perfectionist stance themselves. This need for perfectionism in staff may also be exacerbated by service demands which are often found within the NHS. For example, the continual monitoring of key performance indicators, analysis of service wait times and the amount of clients that can be discharged under each staff member due to being ‘recovered’. Hoggett (2018) explores this concept in his work regarding psycho-social defences in organisations. He argues that when services are deemed to be failing or subject to scandals, which the NHS so often is by mainstream media, organisations respond with ‘knee-jerk reactions’ to ease said anxieties. Often, this is through the tightening of systems and procedures as if they are to blame, to the detriment of human interaction and decision making. Thus, as demands on staff quickly increase, there is less time to engage in relational work and a greater emphasis on getting tasks completed correctly. This further compounds the potential need for perfectionist behaviours in staff.

4.1.4 Theme Four: The Importance of Feeling Valued

This theme summarised the systemic factors that participants felt aided their effectiveness when working with mothers diagnosed with EUPD. As such, three sub-themes were created: *Reciprocal Appreciation*, *Leading by Example* and *Feeling Part of a Team*. The main narrative within all sub-themes was a description of feeling valued and subsequently providing valuable relationships to others. There was also a perception of having good job satisfaction.

In the sub-theme *‘Reciprocal Appreciation’*, participants explain more than just appreciation for their clients but the ways in which they are changed by the work. Literature exploring the impacts on staff who work with clients diagnosed with EUPD tends to focus on burnout (Moore, 2012), as exhibited in the theme above. For staff to express how they are positively impacted by this client group is an alternative narrative to witness. Recently, Crawford et al. (2010) found that levels of job satisfaction within staff working in a community based personality disorder service was higher than expected, with levels of burnout lower than expected. Notably, clear leadership and strong team work was self-reported by staff as being mediating factors within their satisfaction. This corresponds to the next two sub-themes found within the current study, which were the same two reasons that participants felt increased their job satisfaction in relation to this client group.

In the sub-theme *'Leading by Example'*, participants expressed their profound appreciation of their management and that without such management they may struggle to work as effectively with mothers diagnosed with EUPD. By managers being available, present and reflective, participants seemingly describe the ways in which they feel contained. The notion of containment, as discussed in chapter one, has been widely explored in psychological literature, primarily between therapist and client (Billow, 2000). Similarly, it is applicable in a relationship between a manager and staff member. This was alluded to when participants provided examples of managers being present, non-hierarchical, available and reflective. If participants feel contained by their managers, it is likely they are then better able to contain the mothers they are having contact with on a daily basis. Thus, they appear to engage in a cyclical role of being containers for the mothers whilst also being contained by managers. Furthermore, participants' sense of containment seemed to extend between team members too. In the sub-theme *'Feeling part of a team'*, they describe how colleague bonds help them to remain effective when working with mothers diagnosed with EUPD for reasons such as holding risk, being able to debrief and feeling supported. However, as mentioned in the theme above, the need for perfectionism may be increased when working in a team with such dynamics. For example, a participant noted how she does not want to let the team down due to feeling like the weakest link. Moreover, working in a team where such bonds are created may cause dilemmas when authority needs to be exercised. For example, when working with clients who exhibit high risk behaviours it is likely that crisis episodes may occur. If a colleague needs to exercise authority over another colleague or if they respond in a way which another colleague disagrees with, it may be harder to report to the appropriate channel when such bonds have been established. Nonetheless, without such bonds the staff may struggle to work in such high-risk and complex environments so this sense of togetherness needs to be maintained. Ideally, participants would be able to reflect within their teams on the double-bind of wanting to create a supportive team ethos whilst being aware of the difficulties and differences of perspective that can arise. Therefore, it would be useful for services to become more aware of their organizational strengths and weaknesses so as to not enact these weaknesses (Papadopulos, 2015).

4.1.5 Theme Five: Trying to Navigate a Complex System

This theme explored how participants felt perinatal service provision impacts their work with mothers diagnosed with EUPD. Specifically, how it impacts them as staff members. Participants named multiple dilemmas which they face in their work, which led to the creation of two sub-themes: *The Constraints of Time* and *Having to be a Jack-of-all-trades*.

In *'The Constraints of Time'*, participants felt that they do not have enough time to meet the needs of their clients, partly due to the number of women with an EUPD diagnosis on their caseloads. To try and meet these needs they are then overexerting themselves to ensure the safety of their clients, giving examples such as working late and attending back-to-back appointments with no break. In order to minimise time pressures, it could be suggested that perinatal services would need increased funding to ensure greater recruitment of perinatal staff. Theoretically, the more staff that are recruited, the less caseload numbers each person would need to manage. However, perinatal services have already received £140 million in funding for the financial year 2020/21 to meet the objectives of the NHS Long Term Plan (NHS England, 2019). Yet, from participants' accounts this additional funding is not helping with the pressure of caseload numbers and staffing levels. Moreover, within this sub-theme participants noted a tension between psychological provision that they feel clients diagnosed with EUPD require and the amount of psychological input that is given. This tension was heard from the accounts of psychology staff and non-psychology staff, both explaining how time pressure impacts the decision of who is able to engage in longer-term therapy. Due to the planned expansion of perinatal criteria from 12 to 24 months postnatally, it may be possible for longer term psychological support to be offered to mothers given that they have more time to engage in the work. However, as the need for psychological input increases, unless greater numbers of psychological staff are recruited there will continue to be a gap between psychological need versus psychological provision. As such, this sub-theme has indicated there are many complexities perinatal staff are trying to navigate, all whilst trying to maintain safe care for all.

In the *'Having to be a Jack-of-all-trades'* sub-theme, participants spoke about the complexities of their specific roles. They discussed how there is no set guidance to follow when working with mothers diagnosed with EUPD and how they take on multiple roles to meet clients' needs. They described how this can leave them feeling unsure of what work they should be completing and a sense of fragmentation. The notion of a jack-of-all-trades worker has been explored by Leah (2020) who interviewed approved mental health professionals (AMPHs) conducting mental health assessments. The results suggested a 'professional hybridity' of AMPH workers due to the complex and multifaceted roles they take on. This was found to lead to confusion and dilemmas when having to engage in multiple roles. The fact that participants in the current study expressed a fragmentation of their role when working with mothers who have an EUPD diagnosis suggests that although they feel contained by management, there is a lack of containment happening more generally regarding the remit of their work. Additionally, it could be said that by participants having to take on hybrid roles, it mirrors that of a mother and new-born child. This suggests a maternal transference and/or mirroring of the maternal role between staff member and client, which staff may not recognise. If staff are able to reflect on the cases where they particularly feel a destabilisation of their role, this may allow them to notice any possible transference which may impact their work.

4.1.6 Theme Six: Where does the Responsibility Lie?

The final theme also explores participants' views of systemic issues in perinatal service provision, concentrated on the issues for the mothers diagnosed with EUPD rather than themselves as staff. Two sub-themes were crafted: *The Domino Effect* and *The Invisible Women*.

The first sub-theme *'The Domino Effect'* explored participants' views of community mental health teams and how they feel women who are pregnant with an EUPD diagnosis are automatically referred to a perinatal team because CMHTs do not feel well equipped to support these women. Additionally, participants described issues with being able to refer women back to CMHTs once they have received their perinatal treatment, due to wait lists being too long or their referral being rejected. Participants expressed that they do not feel content discharging these women with no onward help so they keep them under their care, consequently increasing the number of women on perinatal caseloads. The views of CMHT provision for women diagnosed with EUPD was discussed in nearly all interviews. Participants felt strongly about these challenges but felt exacerbated by the breadth of the issue and how it could be rectified. Whilst these difficulties were very evident for participants, it is interesting to consider why this area seemed to create the greatest emotional reaction. Previously mentioned in section 4.2.2 '*We're in this Together – The Work is Relational'* was the potential difficulty of discussing emotional responses to challenging clients as staff members. This can be due to lack of appropriate outlets to discuss such views, or a lack of awareness at their own emotions. When staff suppress their emotional feelings and reactions to clients, Vaillant (1994) proposes that these emotions can be relocated and reattached to another idea. Kurtz (2005) found that when mental health staff were interviewed about aspects of job related stress, they would often implicate working conditions and organisation pressures as more problematic than contact with service users. Kurtz (2005) believed it is easier for staff to displace feelings of anxiety and frustration into concrete external issues rather than voice their personal feelings about clients. This relates to the aforementioned discussion regarding ‘hate in the counter-transference’ and how it could be deemed unacceptable in NHS culture to discuss ‘negative’ feelings regarding clients. Furthermore, staff reactions to organisational issues has been explored by Roberts (2003) who posited that many teams are created as an alternative to another, which creates a group identity of being alternative or superior to the other team. This could be applied to perinatal services and CMHTs, with the former being considered a specialist service and the latter a generic one. Roberts (2003) suggests this creates a ‘them and us’ culture, whereby everyone within the specialist team must support the same group ideology, to serve as a defence against the stress of their role. Thus, although participants’ concerns regarding CMHT pressure are legitimate and valid, it is important to consider whether any of these reactions are in part being displaced from client difficulties due to it being more acceptable to discuss. Additionally, from a systemic point of view, participants’ views regarding lack of CMHT involvement indicates that unless there is a greater integration and communication between services, then clients with long term needs may feel perpetually unsupported and the level of intensive support offered by perinatal services may not be sustainable. National perinatal service specification guidance states that “pre-existing serious mental illness in pregnancy will usually be under the care of adult mental health services. Specialised perinatal mental health teams will either advise on management and treatment, take over the care of the woman temporarily or co-work with the psychiatric team, according to individual need and choice” (RCPsych, 2018, p. 12). However, participants’ narratives suggest that this guidance is not being adhered to by CMHT providers. Lever-Taylor et al. (2021) explored the views of women who accessed mental health support during the perinatal period from either perinatal services or generic CMHTs and found that the mothers who received support from CMHTs valued the continuity of care that was provided by CMHTs. However, their recommendations were that CMHTs should not discharge or refer women to other services simply because they become pregnant and that CMHTs require greater levels of training for how to work with women in the perinatal period.

The second sub-theme *'The Invisible Women'* explored novel insights into how participants felt women with an EUPD diagnosis have been forgotten about in perinatal service provision and specialist mental health services generally. This affirms the work of Gamlin et al. (2019) who found that the majority of clients diagnosed with EUPD in England are managed by CMHTs and have less contact with specialist mental health services, despite the need being present. As mentioned above, although perinatal services work with women who experience a mental health condition directly related to pregnancy or one year postnatally, such as post-partum psychosis and perinatal OCD, perinatal services should also treat women who have pre-existing mental health conditions which are exacerbated by pregnancy and childbirth (RCPsych, 2018). Thus, both categories should be treated with equal importance, yet participants' narratives suggest the pre-existing conditions were less acknowledged in perinatal design and commissioning. Another example of how participants felt women with an EUPD diagnosis were essentially forgotten was that these women often receive their first episode of support when entering the perinatal period, as their thresholds are lower than CMHTs. Consequently, it could be questioned what support these women received before perinatal services were established. For example, it was only eight years ago when 40% of England did not have a perinatal team in their community (NHS England, 2019). However, the needs of women with a diagnosis of EUPD would have still been prevalent in the perinatal period, which means they must have been seen by an alternative service if their area did not have a perinatal service. Now that all 44 local NHS areas in England do have a perinatal team established, it begs the question of whether CMHTs are referring women into the team rather than hold them themselves, as they previously would have done, because it is more accessible. Additionally, it is important to consider why women with this presentation may have become invisible and what drives this discourse. For example, the ‘First 1001 Days’ is an initiative from the World Health Organisation (2015) which highlighted the importance of the first 1001 days in an infant’s life for their cognitive, emotional and physical development. A governmental review of this initiative took place in 2020 and outlined the ways in which this vision can be propelled in society. Yet, this is in juxtaposition to the actions of the UK government. For example, Sure Start was a 1998 initiative to ‘give children the best possible start in life’ through health and family support using outreach and community development. Over 3,500 Sure Start centres were established in local communities as a result. However, since its conception in 1998, over 1,300 of these centres have been closed. Thus, women who may have been able to receive support and guidance from community centres no longer have this option. As a result, the prevention of maternal mental health issues seems to have been disregarded, likely putting an increased strain on perinatal services.

4.2 Strengths and Limitations

4.2.1 Sample Size

The sample size of the current study is both a strength and limitation. It is a strength of the study as it adheres to the recommended guidelines for a doctoral project using reflexive thematic analysis (Clarke & Braun, 2013). To have been able to interview 13 participants is notable given they are working members of NHS staff, who consistently spoke of time pressures within their interviews. Nonetheless, to have recruited thirteen participants can also be a limitation. This is because ethical approval was granted from three separate NHS trusts, whereby the study information sheet was sent multiple times to all perinatal staff working within these localities. This can be assumed to be reaching an audience upwards of 50 people. Therefore, to have only recruited 13 participants suggests a disconnect between the need for perinatal research and the recruitment of participants. When questioning why uptake may have been slow, it could be that participants did not have a specific interest into the area of EUPD and therefore did not have a desire to participate. However, it appears that time to engage in an interview was the largest barrier to participation. In nearly all 13 interviews and the sub-theme 'The Constraints of Time', participants discuss a lack of time to complete their daily work. If they are then asked to complete an interview for no direct reward, it is understandable why recruitment may have been low. Furthermore, some participants at the end of their interviews told the researcher that they knew of other members in their team who expressed an interest in participating, yet these people never made contact. This suggests that there was a desire to participate but that barriers were hindering this process. It may also reflect the lack of reflective thinking space available to perinatal staff as was reflected in participants' narratives surrounding burnout. This is concerning given that NHS staff hold valuable opinions and deserve their voices to be heard. If they are keen to participate in research but are unable to, it means their voices are being silenced in a way that will harm them and their clients as their frontline experiences are overlooked. This would need to be considered in future research, which should allow for a substantial amount of time to recruit NHS perinatal staff.

4.2.2 Participant Demographics

Due to the low uptake of participants, the participants included in the study was extended from nurses to all practitioners and psychological staff. Therefore, the 13 participants included in the study held a variety of professional roles such as psychologists, nurses and occupational therapists. Like above, this could be seen as a both a strength and limitation. It is a strength of the study as it increases its transferability due to differing professions being represented. Rather than just focusing on practitioner experiences, it meant a wider breadth of people were able to engage in the research. There was also some continuity in what participants from different professional backgrounds and services expressed. However, it also means that less unified experiences were heard. For example, the training of a psychologist and the training of a nurse is entirely different, meaning some participants held very different viewpoints from each other. Therefore, the experiences they reflected on was based upon their positionality within the team and within their professional body. Nonetheless, by including different professions within the study it gave depth to the results as it allowed alternate viewpoints to be expressed and presented simultaneously.

The majority of participants within this study were white. This is reflective of the population living in the locality where most participants were recruited from. However, the lack of diversity represented within the sample group is a limitation. This is because staff from racialised backgrounds may hold differing views to their white counterparts, due to their own positionality. Data from 2020 revealed that 20% of the NHS workforce are from a racialised background, compared to 80% of white staff (NHS Workforce, 2020). McGilloway et al. (2010) found that there was a small but significantly lower prevalence of personality disorder diagnoses amongst black populations compared to white populations. However, they concluded that this may be due to black individuals being overlooked in mental health services. Therefore, future perinatal research would benefit from increased diversity within sampling, so as to represent a wider majority of views as well as recruiting from ethnically diverse localities, so that participants are able to reflect on working with more diverse populations.

4.2.3 Transferability and Methodology

A strength of this study is its inclusion of participants from three perinatal services. This enhances the transferability of the current study as it means the results are not biased towards one particular service. Furthermore, the transferability of the results is increased due to the structure of perinatal services. As previously discussed in chapter one, perinatal mental health services in England all adhere to the same perinatal mental health pathways. Thus, it can be suggested that the results found in this current study are highly applicable to other perinatal services, as the structure would be the same. There will of course be differences in how these services are managed and organised but overall this is a strength of the study.

A further strength of the current study is the researcher's robustness when adhering to thematic analysis as they rigorously followed the six stage approach outlined by Braun and Clarke (2006; 2019). Additionally, the reflexive element has been upheld throughout. The researcher kept an in depth reflective log for the entirety of the study and noted any biases. Moreover, the semantic and latent approach to analysing this research can be seen as a strength. This is because the latent analysis has widened the perspective beyond those of the individual experiences, particularly the social discourses that may have informed such experiences, drawing on the feminist epistemological position and psychodynamic paradigms. Feminist discourses can often be disregarded in social science research (Wigginton & Lafrance, 2019), meaning it is important to discuss these discourses where possible. Similarly, using a psychodynamic paradigm has allowed for an explanatory account of the social and organisational discourses that arose from the results to be explored. However, it can be viewed as an under elaborated research paradigm which is subjective in nature (Frosh & Emerson, 2005).

A limitation of the study's method is that participants used their own judgement when choosing suitable cases to reflect on. The researcher did not have ethical approval to access perinatal case notes meaning although participants were told to reflect on examples of mothers who have an EUPD diagnosis, it could not be ascertained whether the clients they were discussing met this criteria as it was the participant's subjective decision. Future research could mitigate this limitation by gaining further ethical approval to access perinatal case notes, so that the cases discussed can be verified against the clinical records. Additionally, the use of the term ‘effective’ working within the research title and aim could be considered a limitation as it may have influenced what was expressed by participants. They may have felt restricted in the amount of non-effective working they discussed. Nonetheless, this was mitigated by the interview topic guide also asking about challenges with this client group, to give a more rounded sense of experiences.

Finally, the novelty of this current is a major strength. To the best of the researcher’s knowledge this is the only study in the UK to investigate this topic area. By looking at how perinatal staff work effectively with mothers diagnosed with EUPD, it has shed light on a subject often overlooked. Highlighting experiences of effectiveness and service provision not only leads to clinical implications for staff members but also the mothers accessing perinatal care. These implications will now be discussed.

4.3 Implications and Recommendations

4.3.1 Clinical Level

4.3.1.1 Staff Reflective Support. This study has highlighted the importance of staff support when working with mothers diagnosed with EUPD. Additionally, participants shed light on the importance of reflecting on their emotional responses to their practice and the challenges that occur. Therefore, a recommendation of this research would be the continued need for reflective spaces for staff. However, the researcher is aware of the complexities surrounding reflective practice attendance. For example, participants discussed how they do not have time in their day to attend all clinical appointments, let alone reflective spaces. Furthermore, participants held differing views on reflective spaces dependent on their role. Psychologists found themselves advocating for these spaces but nurses discussed how talking about themselves can feel uncomfortable. It is recommended that provisions are put in place by service managers to make sure that staff can attend the reflective spaces offered to them, without this hindering their daily work. This would be in keeping with the widely recognised requirement that in order to provide containment and good enough care to others, staff require some comparable support themselves (Douglas & Rheeston, 2009). Service specifications should incorporate indirect support time, along with direct contact, in order to ensure staff retention and reduce the likelihood of burnout. For professions where supervision and consultation are less familiar, attention would need to be given to how such familiarity is established. Within the reflective spaces it would be recommended that the facilitators initiate a conversation regarding naming difficult emotions and what can hinder this process. Given that previous research has highlighted levels of burnout when working with complex trauma and EUPD presentations, it is important that staff are given an outlet to discuss their honest opinions, so that these feelings do not get suppressed or displaced into external issues. This would likely require modelling by service managers to help initiate honest conversations. Butler and Fredman (2016) discuss the importance of staff feeling able to name in supervision feelings of arousal and disgust towards clients. These taboo subjects are often diminished in services but it is hoped that by having more honest conversations, staff would be at less risk of burnout as they can name, rather than suppress, difficult emotions.

4.3.1.2 Auditing Caseloads. One area of discovery from this thesis is the number of women with an EUPD diagnosis accessing perinatal care. Participants expressed their surprise at the vast majority of women they meet with this diagnosis. They discussed how they did not expect their caseloads to hold so much of this presentation and feel the level of women with complex mental health needs accessing support does not match the corresponding funding. The psychological lead of the perinatal service within the trust where most of the recruitment took place contacted the researcher two months after recruitment had ended to share results from a recent service audit. They found that 80% of the women they were currently treating had complex need presentations. They were surprised by these results and did not expect this amount. Therefore, it is recommended that all local services conduct routine audits to ascertain the level of women who meet a diagnosis of EUPD under their service. This would raise questions as to why the need may be so high and what can be done to address it. Like the majority of recommendations that will be presented below, as the topic of EUPD and perinatal care seems so scarcely discussed, these audits would be a good place to begin a conversation. This alone would hold powerful implications, rather than perpetuate the narrative that these women are forgotten about. Perinatal service specification states that “Personality disorder should not be a barrier to specialist care” so it is important this is being adhered to (RCPsych, 2018, p. 17).

4.3.2 Policy Level

4.3.2.1 Auditing Services. Alongside the recommendation of local services conducting audits, commissioners and executives at NHS England level need to audit the number of mothers diagnosed with EUPD entering perinatal services as participants felt that commissioners were unaware of the number of women with this type of presentation accessing perinatal care. Whilst local services can endeavour to understand their own throughput, if there are greater numbers of these women accessing care than what has been commissioned for, action needs to be taken at a policy level to ensure these needs are met. Initiating this conversation would be useful, as this is a client group which seems to have been forgotten about in multiple realms of service design. Thus, taking action to truly understand the number of women with this presentation who are needing perinatal support would be one way of starting this conversation.

4.3.2.2 Trauma Informed EUPD Pathways. This research has highlighted the complexities that can occur when staff are working with mothers who are diagnosed with

EUPD alongside multiple other presentations. Participants felt that mothers diagnosed with EUPD deserve greater recognition from services. Thus, in an ideal scenario, mothers presenting with an EUPD diagnosis would be able to access their own pathway within the perinatal model, which is trauma informed in its approach. The beneficial impacts of trauma informed approaches are widespread (Sweeney et al., 2016) yet it is important to recognise the misconceptions that can arise from trauma informed approaches (Sweeney & Taggart, 2018), as it is an ‘approach’ rather than a strict set of guidelines and thus not always translated into service design, despite services promoting themselves as trauma informed. Nonetheless, if perinatal services created pathways specifically for complex trauma and made effort to adhere to trauma informed approaches, it would mean that individuals could work practitioners who have specific interest in this type of presentation and the enhanced knowledge of trauma presentations. Furthermore, participants described how working with mothers with complex trauma feels distinct from the other presentations, whereby they may have different diagnoses but the general skills and treatment used is effective for all. This is in contrast to EUPD presentations where they felt these women require long-term, standalone treatment that is person centred. By having such a pathway, conversations could be started regarding the type of treatment these women receive, the length of treatment that can feasibly be offered under the perinatal team and a general consistency of what treatment is offered to this cohort of women if they are understood in terms of their need arising primarily due to developmental trauma. If these specific pathways were actioned with clear guidance on what the perinatal pathways can and cannot do, it may give a greater sense of clarity to not only the perinatal worker but also the CMHTs. This is because it would hopefully begin a conversation between the services as to who holds what responsibility when a mother is accessing both services, as well as what treatment she would receive under the complex trauma perinatal pathway, meaning CMHTs would have a greater understanding of the remit of the perinatal provision. The Royal College of Psychiatrists (2021) published a report which outlined the provision of good-quality mental health services for pregnant women. The document outlined the close working links that need to be established between CMHTs and specialist perinatal services but from participants' accounts in the current study these links do not seem to be adhered to.

4.3.2.3 Refining Staff Roles. Given that redesigning perinatal services to allow for specific EUPD/trauma informed pathways is a large task, recommendations can be made for the way services are currently designed. For example, if practitioners continue to work with multiple presentations at once, it is recommended that the role of a practitioner who is working with someone diagnosed with EUPD is given greater consideration. This is because the jack-of-all-trades narrative that arose from this research highlights a need for staff to be given further guidance for this type of presentation, so that they can feel more contained. Participants felt like they are not offering any specific type of treatment, nor are they sure of what skills they should be imparting to these women. All work tends to come with a degree of holding multiple roles but these are usually clearly defined and achievable. Additionally, when working in such multifaceted roles, supervision and working flexibly can be imperative to staff feeling supported and able to manage the work. However, at present it seems unsustainable for staff to continue this hybrid working where the boundaries are blurred on what they can and cannot offer mothers as they feel they are part nurse, part therapist, part care-coordinator and so forth. The role needs some refinement, with specific guidelines being made at a policy level so that this can be filtered down to local services. Again, it seems that the first step would be to open up this conversation at policy level, so that commissioners and policy decision makers are made aware of the complexities staff face within their role.

4.4 Future Research

In light of the current study, a possible area for future research would be to expand the current results by asking professionals from additional perinatal services to participate in conversations regarding the same topic but utilising a different methodological approach. For example, interviewing all members of the multi-disciplinary team using focus groups to ascertain their sense of opportunities and challenges that arise when working with mothers with complex trauma. The majority of participants in this study were practitioners who hold lead responsibility for the mothers they work with. Therefore, the role of a practitioner and/or nurse is distinct from other members of the team so it would be helpful to speak to all MDT members. Additionally, by future research continuing to question the same topic area it allows for a greater variability and diversity of results. All participants within this study were recruited from East England. Whilst there is nationally determined perinatal service specifications across localities, how these are implemented in practice will be influenced by the wider local context and the degree to which there is designated and effective support for parents with histories of complex trauma. By expanding the study to incorporate the views of those from a greater number of localities in the UK, there would be a greater level of diversity in regard to the participants themselves and the ways in which services operate.

Furthermore, there would be value in research that focused directly on mothers with complex trauma and their experience of perinatal care. Future research would do well to identify any perinatal services which have engaged in specific initiatives, such as the creation of group programmes specifically for women with complex trauma, alongside their standard service provision. The research could highlight how these initiatives are running efficiently, any barriers that are experienced and a staff and service user perspective on them. It is not uncommon for perinatal services, and NHS services more broadly, to create groups and programmes designed to meet the need of their specific population within their own locality. However, these programmes are not always discussed between services. Therefore, any research that can showcase and highlight work that is being done specifically for this client group may increase the exposure of said programmes, making them more widely available. Finally, considering the relational themes that arose from this research, future studies which interview both mother and staff member who have engaged in relational work together could provide insight in the dynamic nature of interventions and what each person felt to be beneficial or challenging.

4.5 Researcher Reflections

Reflecting on the overall process of completing this thesis I am struck by how many of my own biases have been highlighted and altered. Despite having an interest in working with individuals diagnosed with EUPD, I was surprised when I noticed my bias as to how I thought other people viewed these individuals. Before conducting my interviews with participants I assumed they would talk very negatively and struggle to think about the ‘effective’ element of the research aim. What happened was the reverse; participants spoke with such eloquence, care and thoughtfulness about these clients I was taken aback. I felt guilty about my assumptions and reflected on how these may have been perpetuated from writing my introductory chapter prior to the interviews, whereby the majority of the research seemed to reflect negative discourses. Nonetheless, this too may be a reason why participants tended to avoid discussion of ambivalent feelings about their clients. For example, they may have been aware of such feelings but were aware of the traditional ‘negative bias’ in discourses surrounding EUPD diagnoses and so may not have wanted to further emphasise this narrative, despite some of these feelings resonating with them.

Another example of personal learning was in regard to the feminist aspect of this research. Prior to completing this research I had an awareness of the unfair treatment of women who may have an EUPD diagnosis but little was I aware of the gravity of the situation. Engaging in readings, such as those from Jane Ussher, on the treatment of women throughout mental health history and how women with EUPD are viewed in the context of both sexism and classism was uncomfortable reading. Similarly, my awareness of how mothers are treated by society has increased drastically. I was blinkered to how society can view mothers and my own biases within these narratives. The work of Jacqueline Rose highlighted the total lack of ambivalent feelings that mothers are allowed to express and the hegemonic ideologies regarding motherhood. I reflected on how being a female in her twenties who is yet to have children meant I was somewhat oblivious to this discourse as I am yet to experience the difficulties that motherhood can entail. Reading Bueskens (2018, p. 14) quote “Women can be ‘individuals’ but only on the wager that they are simultaneously prepared to perform all, or nearly all, of the domestic work and childcare. In effect, women can ‘go out’ but they must also (and somehow simultaneously) stay home” made me reflect on the impossible constraints that are set upon mothers and how I may too find myself within this conflict if I do have children. Furthermore, both during and after my participant interviews I noticed myself starting to question areas where I had previously thought I maintained neutrality. For example, I had not given too much consideration as to why perinatal services only work with women. However, from the conversations I had with participants I begun to fiercely question why services are designed in this way and the social discourses that it reinforces regarding greater responsibility on mothers than fathers. Why is it only mothers that can access perinatal support? Why are we putting the sole responsibility on women to do the work? Why are we creating services focused on an individualistic perspective, rather than a systemic one?

Furthermore, the fact that no males participated in this study and participants typically referred to the women in their teams suggests that there is a lack of men working in perinatal services. I now question what social discourses may influence this. For example, that childcare is predominantly a woman's role, so women are the ones who should care for the mothers as they have the greater 'understanding', or perhaps there is a sense of shame for males who engage in perinatal work as they feel they would be judged for preferring to work with female service users, as males should commonly stick together? This is an example of how since partaking in this research I have begun to recognise and then question the patriarchal discourses that are prevalent in society. I am glad that I have this awareness now and could utilise these learnings in this thesis, rather than never at all.

These learnings will stay with me both professionally and personally. Professionally, as a soon to be qualified clinical psychologist it has highlighted the complexities in service design for individuals with complex trauma, specifically how they can be 'lost' or forgotten about in mental health systems. As I enter my newly qualified role, I have learnt the importance of asking how services are funded to meet the needs of different groups and to advocate and question whether complex trauma has been considered in service design, funding and provision. After hearing my participants' narratives I am left with a sense of hopefulness for women with complex trauma/EUPD, as it showcases the care and compassion that NHS staff can exhibit. I believe this research has given voice to an often disregarded topic and I hope that it contributes to helping future perinatal care for both mothers with complex trauma and the staff members that so passionately care for their work.

4.6 Conclusion

To conclude, this study is the first in the UK to explore how perinatal mental health staff work effectively with mothers diagnosed with EUPD. Thirteen perinatal staff from three NHS trusts engaged in qualitative interviews. The interviews were analysed using Reflexive Thematic Analysis. Six themes and 13 sub-themes were crafted which showcase how perinatal staff consider the use of labelling women with this diagnosis, the aspects of the relational work which they feel makes the work most effective and how they as staff influence the working relationship they have with mothers diagnosed with EUPD. Furthermore, the results highlighted the social, organisational and systemic influences which participants felt maintained their effectiveness, the challenges they encounter when working in a system which they feel is not designed to meet EUPD need and the reasons why they feel these challenges occur systemically. The research has generated numerous implications and recommendations for perinatal services. Namely, the high proportion of service users with a complex trauma presentation accessing perinatal care and how the support being offered is unlikely to be effective and sustainable unless it is shared across secondary mental health care services. Furthermore, it recommends that standalone complex trauma/EUPD pathways both across community services and in perinatal services would have potentially helpful implications for staff and service users. Overall, this research has shed light onto a novel but very important area.

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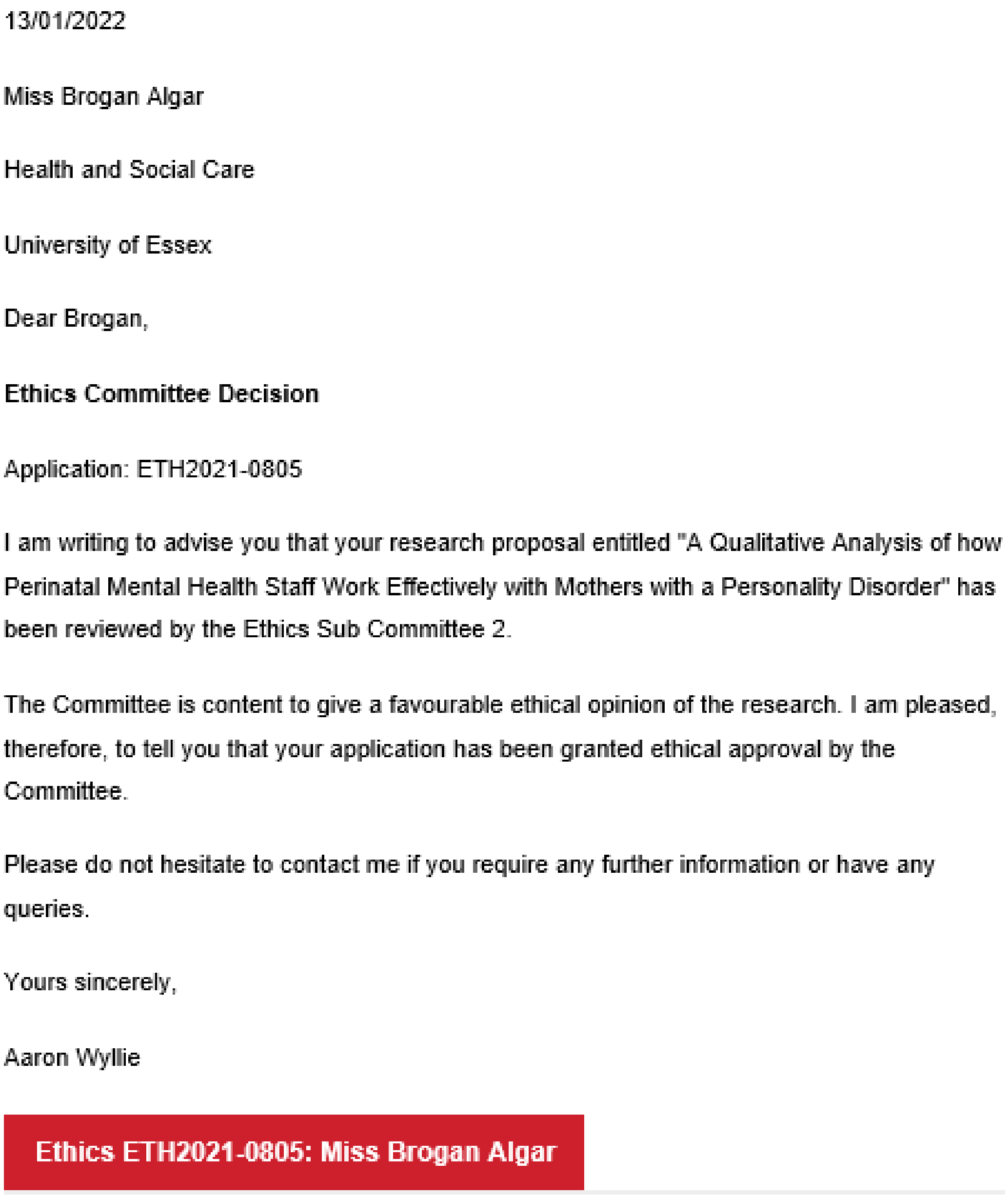
Appendices

Appendix A – University of Essex Ethical Approval



13/01/2022

Miss Brogan Algar

Health and Social Care

University of Essex

Dear Brogan,

Ethics Committee Decision

Application: ETH2021-0805

I am writing to advise you that your research proposal entitled "A Qualitative Analysis of how Perinatal Mental Health Staff Work Effectively with Mothers with a Personality Disorder" has been reviewed by the Ethics Sub Committee 2.

The Committee is content to give a favourable ethical opinion of the research. I am pleased, therefore, to tell you that your application has been granted ethical approval by the Committee.

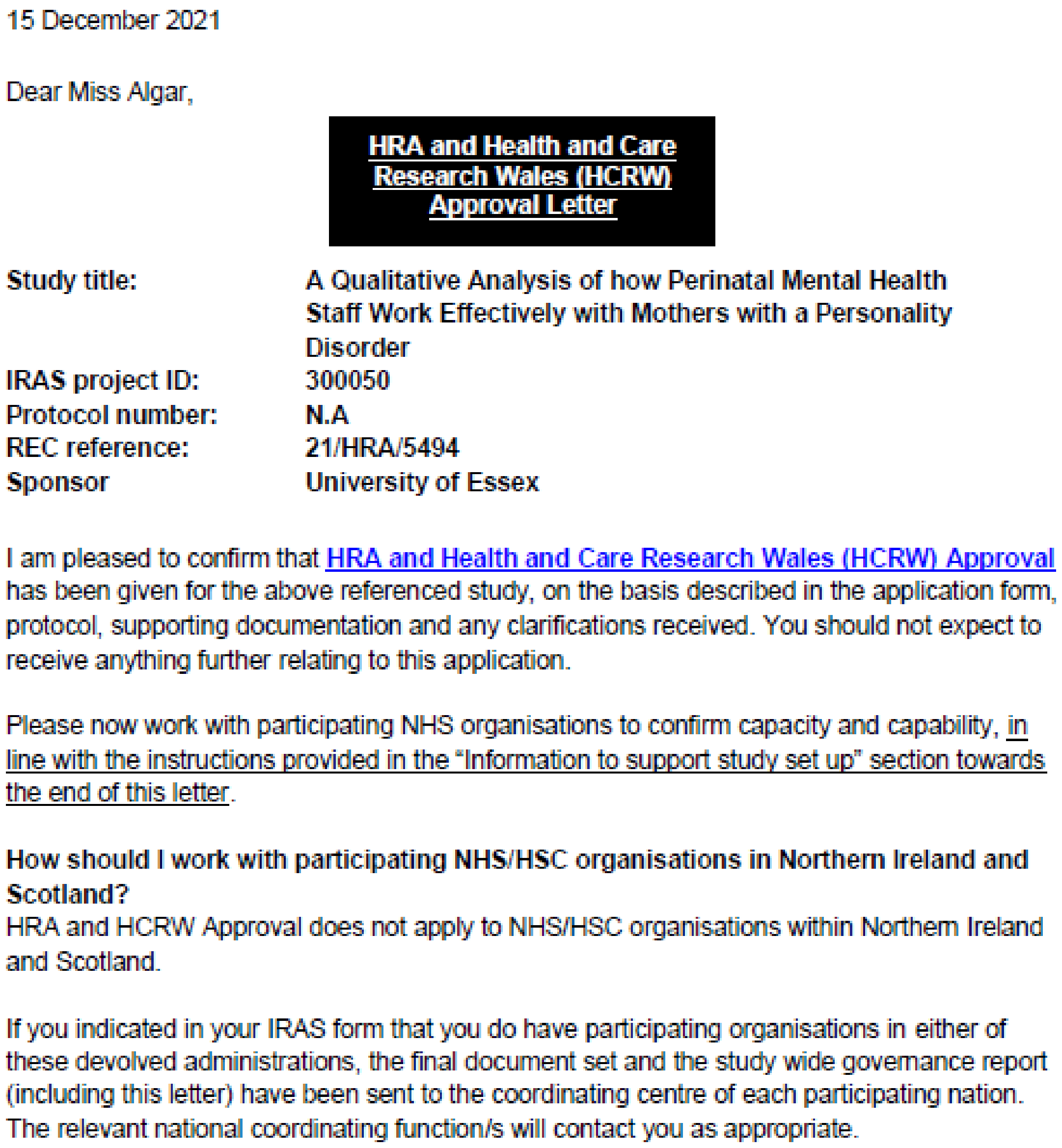
Please do not hesitate to contact me if you require any further information or have any queries.

Yours sincerely,

Aaron Wyllie

Ethics ETH2021-0805: Miss Brogan Algar

Appendix B – Health Research Authority Ethical Approval



15 December 2021

Dear Miss Algar,

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**A Qualitative Analysis of how Perinatal Mental Health Staff Work Effectively with Mothers with a Personality Disorder**
IRAS project ID:	**300050**
Protocol number:	**N.A**
REC reference:	**21/HRA/5494**
Sponsor	**University of Essex**

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Appendix C – Participant Information Sheet

Participant Information Sheet

Project Title: ‘A Qualitative Analysis of how Perinatal Mental Health Staff Work Effectively with Mothers with a Personality Disorder’

My name is Brogan Algar and I am Trainee Clinical Psychologist undertaking a Doctorate in Clinical Psychology at the University of Essex. I would like to invite you to take part in a research study. Before you decide whether to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

What is the purpose of the study?

The purpose of this study is to investigate the experiences of Perinatal Mental Health staff who have worked with mothers with Emotionally Unstable Personality Disorder (EUPD). Research has shown that mothers with EUPD will be at greater risk of perinatal difficulties, that children of mothers with EUPD may be at risk of greater mental health difficulties and that women with a diagnosis of EUPD feel their needs are not met in the perinatal period, yet the experiences of perinatal staff working with mothers with EUPD is unknown. Identifying common themes from staff experiences may help to improve service provision for this group of individuals. This piece of research is being undertaken as part of my doctoral training.

The research team are aware that the term Complex Trauma may be used instead of EUPD. As EUPD is the current diagnostic label used within NHS services it will be used in this research.

Why have I been invited to participate?

You have been invited to participate as you work for a Perinatal Mental Health Team. We are hoping to recruit 12-15 participants for this study.

What will happen to me if I take part?

If you decide you would like to participate, please email the researcher on ba20001@essex.ac.uk to register interest. The researcher will then arrange a mutually agreed time and date for a ‘research interview’. This may be via telephone or video call due to Covid-19 restrictions. You may conduct the call in your own home or working premises but you should ensure it is a confidential space. The researcher will also conduct the interview in a confidential space. On the day of the interview, you will be asked to sign a consent form. Then, the researcher will ask you to fill out a brief questionnaire asking general demographic questions, such as age and gender. You will then have a conversation with the researcher for around 30-60 minutes which will be audio recorded. During this conversation, the researcher will ask you some questions about your experience of working with mothers with a personality disorder. This audio tape will then be transcribed into text by the researcher and the audio recording destroyed. The transcribed data will then be used to identify themes that arose from staff experiences.

Do I have to take part?

No, it is up to you to decide whether you wish to take part in this research study. If you agree to take part, we will then ask you to sign a consent form. You would be free to withdraw at any time, without giving a reason. Both participation and withdrawal would have no impact on your current or future employment as all data is anonymised. To withdraw from the study, participants can contact myself by email on ba20001@essex.ac.uk stating their wish to withdraw. If any information has already been collected from you, it would be destroyed.

What are the possible disadvantages and risks of taking part?

Taking part in this research requires your time. Although unlikely, it is possible that you may find it emotionally upsetting to recall your experience of working with mothers with a personality disorder. The researcher will support you during the conversation if this were to occur.

What are the possible benefits of taking part?

Whilst we cannot guarantee any direct benefits from taking part in this research, having the space to talk openly about your experiences may be helpful and interesting. By participating in the research, you will be helping to provide invaluable information about a topic that has very little research already undertaken. It is hoped that the results of this research will help to improve support for mothers with EUPD and it may be used to inform future research studies.

What information will be collected?

Basic demographic information will be collected from you, such as your age, gender and job title. This data will remain anonymised and no personal identifiable data will be included.

Will my information be kept confidential?

Yes, your participation in the study and all information that you provide will remain confidential. Individuals who agree to participate will be given a unique participant number to protect their anonymity. Data will be stored on an encrypted file on a password protected computer. Any hard data copies will be scanned onto a computer and then shredded. All data will be stored securely for the next 5 years and will destroyed securely after this time. The researcher will transcribe your interview into text format and the audio recording will then be destroyed. Fully anonymised direct quotations from your interview may be used in the final thesis write up. This will not include any identifiable data. Only the researcher and the research supervisor will have access to the data. Whilst unlikely, if during the research you disclose information that leads the researcher to believe that yourself or others are at risk of harm, the researcher may have a duty of care to inform an appropriate authority.

What is the legal basis for using the data and who is the Data Controller?

We (The University of Essex) need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you. Where can you find out more about how your information is used?
You can find out more about how we use your information at www.hra.nhs.uk/information-about-patients/, our leaflet available from http://www.hra.nhs.uk/patientdataandresearch, by asking one of the research team or by sending an email to the University of Essex's data protection team dpo@essex.ac.uk. As this research is being undertaken by a doctoral student, the legal basis for processing your data is through your consent. Consent must be freely given. The Data Controller at the University of Essex is the University Information Assurance Manager (dpo@essex.ac.uk).

What should I do if I want to take part?

Should you wish to take part in this research, please inform the researcher, Brogan Algar, by sending an email stating your desire to participate to ba20001@essex.ac.uk

What will happen to the results of the research study?

The results of the research will be written up as part of the researcher's thesis. The thesis may be submitted for publication in an academic journal or presented at conferences. Some direct quotes for the participants may be used in the write up, but all information is anonymous and no identifiable information will be included. The researcher will provide participants with an electronic copy of the final thesis, should they wish to receive it.

Who is funding the research?

This research is being undertaken as part of a Doctoral research project in Clinical Psychology. The research is funded by the University of Essex.

Who has reviewed the study?

This study has gained Health Research Authority approval and ethical approval from the Ethics Sub-Committee 2 at the University of Essex. It has also been reviewed by your Trust's Research and Development Authority.

Concerns and Complaints

If you have any concerns about any aspect of the study or have a complaint, in the first instance please contact the principal investigator of the project, Brogan Algar, using the contact details below. If you are still not satisfied, you think your complaint has not been addressed to your satisfaction or you feel that you cannot approach the principal investigator, please contact the departmental Director of Research in the department responsible for this project, Dr Camille Cronin Camille.cronin@essex.ac.uk. If you are still not satisfied, please contact the University's Research Governance and Planning Manager, Sarah Manning-Press (e-mail sarahm@essex.ac.uk). Please include the ERAMS reference which can be found at the foot of this page.

Name of the Researcher/Research Team Members

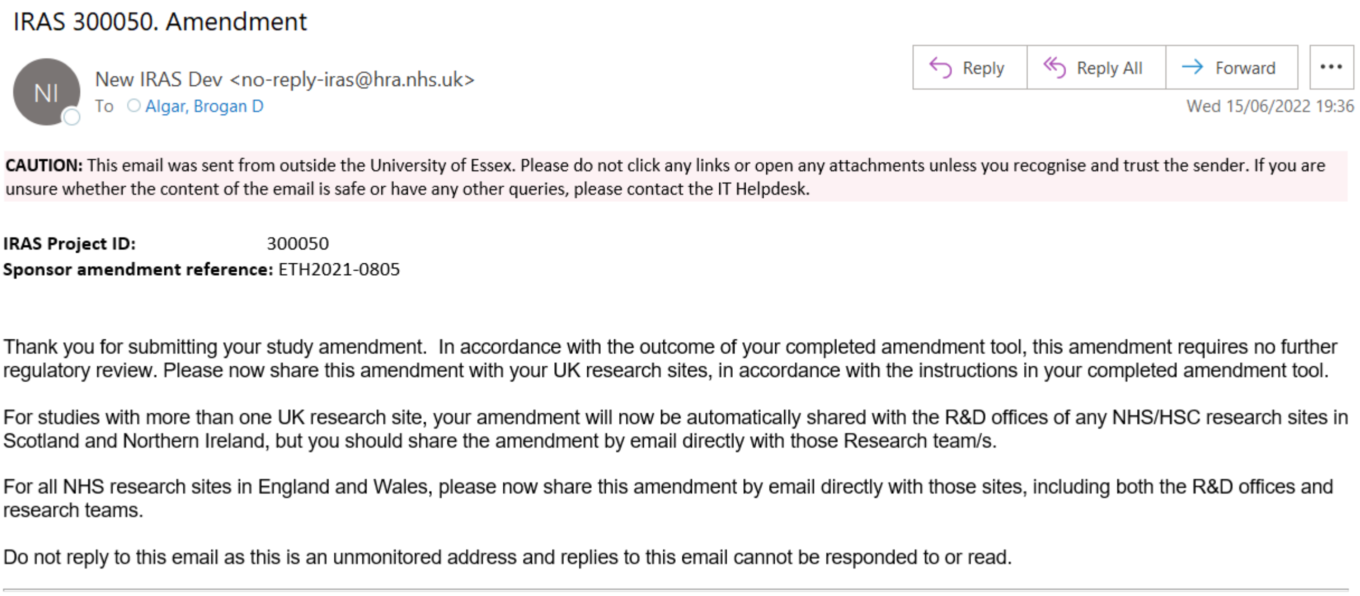
Principal Researcher: Brogan Algar
Trainee Clinical Psychologist, Doctoral Student
Email: ba20001@essex.ac.uk

Research Supervisor: Dr Richard Pratt
Clinical Psychologist and Clinical Tutor
Email: richard.pratt@essex.ac.uk

Research Supervisor: Dr Frances Blumenfeld
Clinical Psychologist and Doctoral Programme Lead
Email: fblume@essex.ac.uk

Participant Information Sheet (Version 2)
ERAMS Reference: ETH2021-0805
IRAS Project ID: 300050
15/12/21

Appendix D – Health Research Authority Amendment Confirmation



IRAS 300050. Amendment

New IRAS Dev <no-reply-iras@hra.nhs.uk>
To Algar, Brogan D
Wed 15/06/2022 19:36

CAUTION: This email was sent from outside the University of Essex. Please do not click any links or open any attachments unless you recognise and trust the sender. If you are unsure whether the content of the email is safe or have any other queries, please contact the IT Helpdesk.

IRAS Project ID: 300050
Sponsor amendment reference: ETH2021-0805

Thank you for submitting your study amendment. In accordance with the outcome of your completed amendment tool, this amendment requires no further regulatory review. Please now share this amendment with your UK research sites, in accordance with the instructions in your completed amendment tool.

For studies with more than one UK research site, your amendment will now be automatically shared with the R&D offices of any NHS/HSC research sites in Scotland and Northern Ireland, but you should share the amendment by email directly with those Research team/s.

For all NHS research sites in England and Wales, please now share this amendment by email directly with those sites, including both the R&D offices and research teams.

Do not reply to this email as this is an unmonitored address and replies to this email cannot be responded to or read.

Appendix E – Participant Consent Form

Title of the Project: A Qualitative Analysis of how Perinatal Mental Health Staff Work Effectively with Mothers with a Personality Disorder

Please cross 'X' box

1. I confirm that I have read and understand the Information Sheet dated 15/12/21 for the above study. I have had an opportunity to consider the information, ask questions and have had these questions answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw from the project at any time without giving any reason and without penalty. I understand that any data collected up to the point of my withdrawal will be destroyed. ☐
3. I understand that the research may require me to talk about emotive topics and will inform the researcher if I wish to stop the interview at any point. ☐
4. I consent to being audio recorded during the interview. I understand that the audio recording will be destroyed as soon as the researcher has transcribed it into text form. This will be fully anonymised. ☐
5. I understand that fully anonymised direct quotations from my interview may be included in the Thesis document. ☐
6. I understand that my fully anonymised data may be used for future publications in mental health journals and it may be disseminated to NHS Trust policy makers and commissioners. ☐
7. I understand that the data collected may be used to support other research in the future and may be shared anonymously with other researchers. ☐
8. I understand that I will receive a copy of my signed consent form and that the researcher's copy will be stored electronically on an encrypted computer which only the research team has access to. ☐
9. I agree to take part in the above study. ☐

Participant Name	Date	Participant Signature
________________________	__________	________________________
Researcher Name	Date	Researcher Signature
_____________	__________	________________________

Consent Form (Version 2)
ERAMS Reference: ETH2021-0805
IRAS Project ID: 300050
15/12/21

Appendix F – Interview Schedule

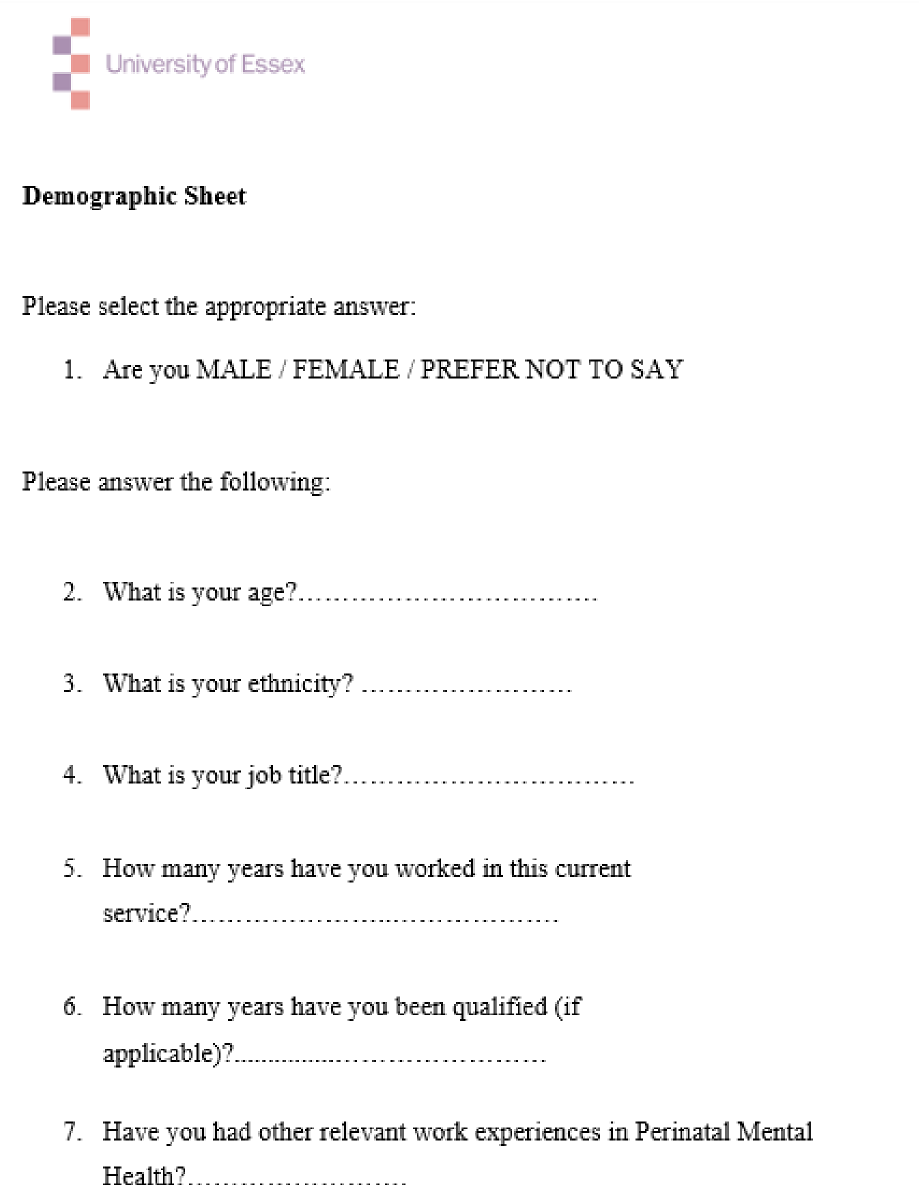
To explore themes evident in perinatal staff discussion about their experience of working with mothers with a diagnosis of EUPD:

- There are differing views on the term “personality disorder” please let me know your thoughts about it?
- To what extent would you say there are specific challenges or issues in working with mothers described as having a EUPD within the context of your service?
- Then discuss the challenges for staff members
- Please can you discuss your experiences of how you worked effectively with one or more mothers diagnosed with EUPD?
    - What helped you to work effectively?

To explore perinatal staff views of perinatal service provision in relation to mothers with EUPD:

- Do you feel you provide an adequate service for mothers diagnosed with EUPD?
    - Please discuss the aspects of the service which have worked well in your experience
- Is there a strong staff support system at your service and does this help when working with mothers diagnosed with EUPD?
- Does the service support any partners of women who have an EUPD diagnosis?
- In an ideal world, what perinatal mental health support would you like to offer for mothers diagnosed with EUPD?

Appendix G – Participant Demographic Sheet



University of Essex

Demographic Sheet

Please select the appropriate answer:

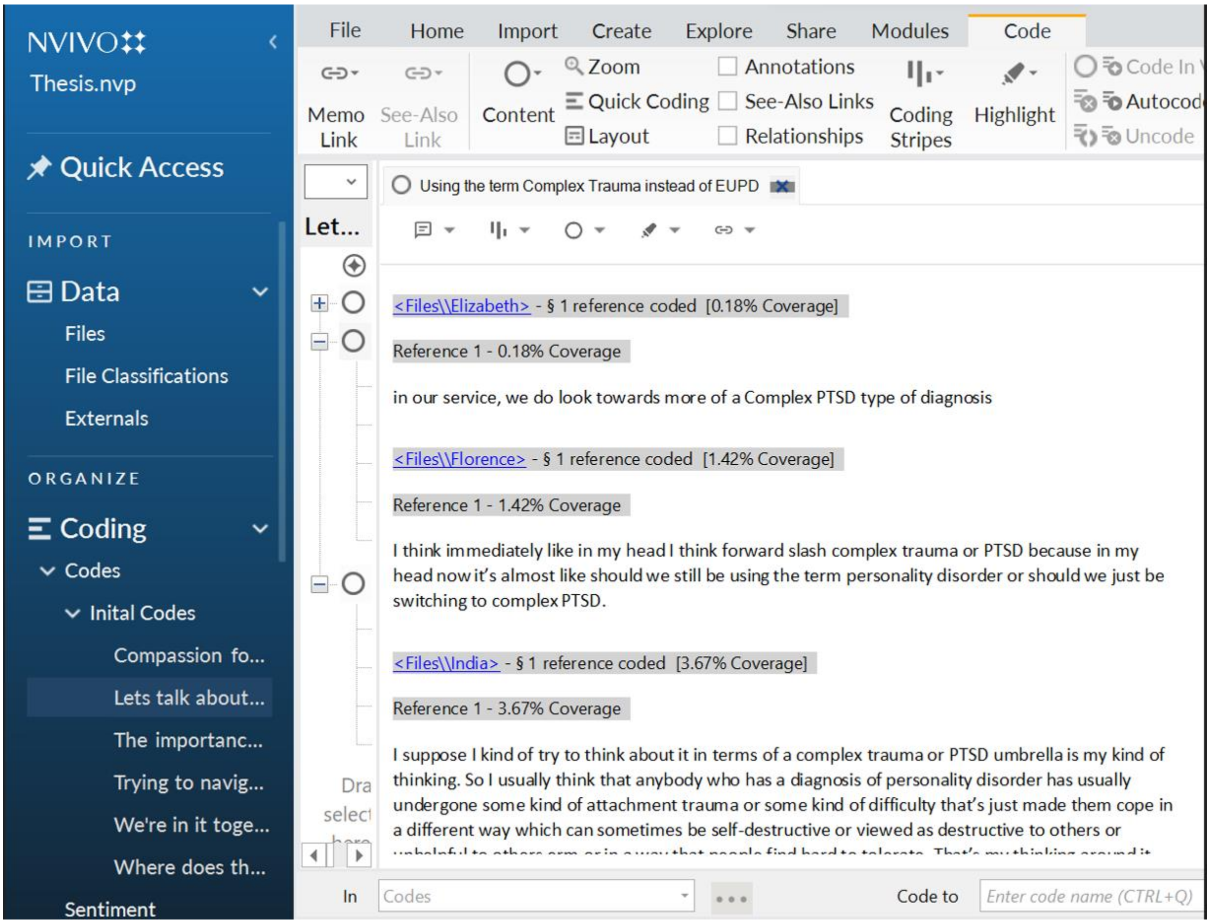
1. Are you MALE / FEMALE / PREFER NOT TO SAY

Please answer the following:

2. What is your age?……………………………….
3. What is your ethnicity? ……………………
4. What is your job title?……………………………
5. How many years have you worked in this current service?……………………..………………
6. How many years have you been qualified (if applicable)?...............……………………
7. Have you had other relevant work experiences in Perinatal Mental Health?……………………

Appendix H – Researcher’s Familiarisation Notes

Appendix I – Coding Example on NVivo Software



○ Using the term Complex Trauma instead of EUPD

<Files\\Elizabeth> - § 1 reference coded [0.18% Coverage]

Reference 1 - 0.18% Coverage

in our service, we do look towards more of a Complex PTSD type of diagnosis

<Files\\Florence> - § 1 reference coded [1.42% Coverage]

Reference 1 - 1.42% Coverage

I think immediately like in my head I think forward slash complex trauma or PTSD because in my head now it's almost like should we still be using the term personality disorder or should we just be switching to complex PTSD.

<Files\\India> - § 1 reference coded [3.67% Coverage]

Reference 1 - 3.67% Coverage

I suppose I kind of try to think about it in terms of a complex trauma or PTSD umbrella is my kind of thinking. So I usually think that anybody who has a diagnosis of personality disorder has usually undergone some kind of attachment trauma or some kind of difficulty that's just made them cope in a different way which can sometimes be self-destructive or viewed as destructive to others or

Appendix J – Themes Analysis Process