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Perinatal mental health practitioners' experiences supporting mothers with Emotionally Unstable Personality Disorder: a qualitative study

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ABSTRACT

Background: Emotionally Unstable Personality Disorder (EUPD) is a controversial and potentially stigmatising diagnosis, especially in women. Limited research exists on how mothers diagnosed with EUPD engage with perinatal mental health services and no United Kingdom studies have explored perinatal mental health staff perspectives on working with this population.

Aim: To explore perinatal mental health staff's experiences of working with mothers diagnosed with EUPD and their views on service provision.

Method: Reflexive Thematic Analysis was used to analyse semi-structured interviews with 13 perinatal mental health staff from three National Health Service (NHS) trusts in England. All participants had direct involvement with mothers diagnosed with EUPD.

Results: Six themes emerged: 1) We're in This Together: the importance of building therapeutic relationships; 2) The Fit Between Staff and Service: what draws staff to this work; 3) The Importance of Feeling Valued: support needs for staff; 4) Navigating a Complex System: service constraints affecting staff; 5) Let's Talk About Labels: the stigma and complexity of the diagnosis and 6) Where Does the Responsibility Lie?: systemic service issues impacting mothers diagnosed with EUPD.

Conclusion: This study highlights the complexities faced by perinatal mental health staff supporting mothers with EUPD. Staff stressed the importance of relational working but also identified social, organisational and systemic barriers to effective care. Findings suggest the need for trauma-informed EUPD care pathways in perinatal services and enhanced staff support structures. Clearer role guidance for staff and improved cross-agency coordination of care would ensure sustainable, equitable care.

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Perinatal; mothers; EUPD; staff; practitioners

Introduction

Emotionally Unstable Personality Disorder (EUPD), also known as Borderline Personality Disorder (BPD), is a mental health diagnosis in the International Classification of Diseases-11 (ICD-11; World Health Organization, 2019). EUPD is characterised by emotional

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dysregulation, unstable relationships, impulsivity, self-harm and an intense fear of abandonment (American Psychiatric Association, 2013). Whilst recent epidemiological data is limited, Coid et al. (2006) estimated a 0.7% prevalence rate in the United Kingdom. In inpatient settings, women are more likely to be diagnosed than men (Zeyrek Eyuboglu et al., 2021). Many individuals report that the term carries stigma and can reinforce negative stereotypes, such as being 'difficult' or 'manipulative' (Lester et al., 2020).

Historically rooted in a medical model, EUPD is now increasingly seen as a manifestation of 'complex trauma', particularly early relational trauma (Porter et al., 2020). Throughout this paper, the term EUPD is used, reflecting its status as a formal diagnostic label within United Kingdom (UK) clinical settings. Where participants refer to complex trauma as an alternative conceptualisation, this is noted in quotations. A meta-analysis of 97 studies found individuals diagnosed with EUPD were 13 times more likely to report childhood trauma than controls (Porter et al., 2020). Feminist critiques of EUPD argue that women diagnosed with EUPD are seen as 'demanding and angry' for displaying behaviours that defy gender norms (Jimenez, 1997). Shaw and Proctor (2005) suggest that the diagnosis is a form of social control applied to women who express anger or aggression, behaviours deemed inappropriate in women but acceptable in men. Consequently, there is growing advocacy to adopt trauma-informed terminology that acknowledges these systemic influences (Kulkarni, 2017).

Despite diagnostic controversy, the symptoms associated with EUPD can significantly affect functioning, especially for women in the perinatal period; from conception of a child to 12 months postpartum (NHS England, 2018). Mothers with EUPD are more likely to experience postnatal depression and have difficulties regulating their own emotions (Feldman et al., 1995; Newman et al., 2007). Perinatal services in England, which are designed to help mothers' mental health during this period, all adhere to the Perinatal Mental Health Pathways (NHS England, 2018), which have five treatment routes: preconception advice, specialist assessment, emergency assessment, psychological interventions and inpatient care.

Existing literature on mothers with EUPD focuses on their experiences with services. Zacharia et al. 2021 interviewed 12 women with a diagnosis of EUPD who had received perinatal mental health support in England. They identified the key themes: feeling judged as 'unfit', struggling to feel heard by services and perceiving that their complex needs were not fully addressed by practitioners. However, the women valued the specialist support they received. Despite this, little is known about how perinatal mental health staff engage with mothers diagnosed with EUPD. Only one UK study explored perinatal staff experiences of facilitating an emotional skills group for this population, but broader experiences remain limited (Moran et al., 2024).

This study aims to examine perinatal staff experiences of supporting mothers with EUPD, highlighting relational and systemic factors that facilitate or constrain effective care within UK services.

Method

First author positionality

My perspective was shaped by previous roles as an assistant psychologist in acute inpatient wards and an adolescent Dialectical Behaviour Therapy (DBT) service. In

inpatient settings, I witnessed gendered, stigmatising narratives around EUPD, often linked to staff burnout and limited trauma awareness. In the DBT service, I considered how adolescents without an EUPD diagnosis might later receive one as a result of their early experiences and how this might shape their journey into motherhood. I have worked with adults with EUPD but not in perinatal services and am not a mother, positioning me as both an insider and outsider. A feminist stance was central to my approach, ensuring I did not reinforce deficit-based narratives and instead shone a light on what participants thought helped or hindered the perinatal care of these women.

Design

This qualitative study followed a critical realist ontology, viewing EUPD as a real construct in the National Health Service (NHS) whilst recognising individual variation. A standpoint feminist epistemology guided the research, recognising knowledge as socially situated and gendered (Belenky et al., 1986). Individual interviews were chosen over focus groups, given the emotive topic and potential discomfort discussing EUPD cases among colleagues (Newton-Howes et al., 2008).

Participants

Thirteen participants were purposively sampled (Table 1). Participants were included if they worked in a community perinatal mental health team and had experience of working with mothers diagnosed with EUPD. Nursing and psychology staff were selected due to their consistent patient contact. Participants were excluded if they had worked in the perinatal service for less than 12 months or if they worked in a mother and baby unit (MBUs) or parent-infant teams (PIMHs). These specialist services operate under distinct clinical frameworks from community perinatal teams and their inclusion would have introduced variability better examined in a separate study. Community teams typically manage broader caseloads with fewer embedded psychological resources, which may have shaped staff reflections. Focusing exclusively on these teams means the findings reflect the culture and resource profile of these services rather than specialist MBUs or PIMHs. Consequently, the findings are most transferable to comparable community settings rather than inpatient or specialist services. No men participated, likely reflecting the perinatal workforce demographic.

Procedure

Ethical approval was obtained from the University of Essex and the UK Health Research Authority. Recruitment began in one NHS trust in East England, then expanded to two additional trusts due to low uptake. Perinatal team leaders circulated the Participant Information Sheet to staff via email. To avoid potential coercion through service hierarchies, team leaders distributed a general study invitation but were not involved in selecting or encouraging participants. Staff who wished to take part contacted the researcher directly and participation remained confidential. Eligible staff scheduled an interview and provided written consent. Participants selected their own case examples of mothers with an EUPD diagnosis to reflect on.

Table 1. Participant demographics.

Demographic	Category and Number of Participants (N)							
	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	-	-	-	-	-

Interviews were audio-recorded, transcribed within 48 hours and recordings were destroyed. Anonymised data were stored securely on password-encrypted devices and pseudonyms were used to preserve confidentiality. Only the research team accessed study data. The first author conducted all interviews, analysis and write up, with supervision and review from co-authors.

Data analysis

Data analysis followed the six stages of reflexive thematic analysis (Braun & Clarke, 2006, 2019). The first author immersed themselves in the data by re-reading and memoing in NVivo 13. Then, preliminary codes were identified using data deemed 'interesting and meaningful'. Initial coding was broad to capture all potentially relevant data. To ensure rigour, two coding runs were conducted (Braun & Clarke, 2021); first top-down, the second starting mid-dataset. Once initial coding was complete, codes were printed and manually sorted into provisional overarching themes. Some codes needed to be disbanded or separated to allow theme construction. Appendix A includes a reflexive diary excerpt of the researcher's approach. Reflexive notes informed analytic decisions throughout. For example, initially staff accounts of mothers' disengagement were coded as individual ambivalence. Reflection, informed by the research team's feminist stance, reframed these accounts as responses to gendered and moral expectations of motherhood. Themes were reviewed with co-authors and named to capture their essence; analysis was primarily inductive within a feminist lens.

Results

Six themes and four sub-themes are outlined in Table 2, with paired service recommendations.

Theme one: we're in this together

This theme explores the relational dynamics participants saw as essential when supporting mothers diagnosed with EUPD. All participants emphasised the importance of building trust and empathy. They described a relational approach of '*walking alongside*' the mothers, rather than taking an authoritative stance. They also highlighted the value of consistency:

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. (Clare)

Participants described how their approach echoed trauma-informed, attachment-focused principles, rather than focusing on '*fixing*' the mothers. They recognised that the perinatal period activates past relational trauma for these women, such as:

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 (India)

Many participants referenced the concept of '*ghosts in the nursery*' (Fraiberg et al., 1975) and the mothers' desire to break intergenerational cycles of trauma:

Table 2. Overall themes and sub-themes with service recommendations.

Theme	Sub Theme	Service Recommendation
We're in This Together	–	Embed trauma-informed, attachment-based training to strengthen relational practice and promote consistency of care
The Fit Between Staff and Service	–	Provide clear role definitions, supportive supervision, and manageable caseloads tailored to complex cases
The Importance of Feeling Valued	Feeling Part of a Team	Implement protected reflective spaces and supervision time to support staff wellbeing
	Reciprocal Appreciation	
Navigating a Complex System	Having to be a Jack-of-all-trades	Develop and implement multidisciplinary care pathways specifically for mothers diagnosed with EUPD
	The Constraints of Time	
Let's Talk About Labels		Develop and implement multidisciplinary care pathways specifically for mothers diagnosed with EUPD
Where Does the Responsibility Lie?		Conduct audits to inform funding and promote integrated service commissioning

So many women come in and say I want this to be different. I want this to be different to how I was parented. I don't want to repeat what my experiences were (Charlotte)

This relational steadiness provided emotional safety, enabling mothers to explore distress without fear of judgement and positioning the therapeutic relationship itself as a central vehicle for change. By understanding and addressing these attachment wounds, perinatal workers felt they could foster more secure relationships with mothers.

Theme two: the Fit Between Staff and Service

Theme two summarises what enables staff to engage in this work. Participants spoke of a need, both within themselves and from a managerial level, to reflect on how the work with mothers with a diagnosis of EUPD made them feel.

I think also being able to name but in a safe way what we bring to the party as well ... 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 enough (Charlotte)

Acknowledging one's emotional reactions was central to ensuring effective practice. Participants described how being able to reflect on their emotional responses allowed them to maintain a more *'empathetic'*, grounded approach, avoiding over-identification with the service users while still offering compassionate care. Staff recognised a need to name any *'maternal transference'* they may have with service users. Participants often adopted a maternal role:

I think the other thing as well which I've noticed ... is that the women [staff members] that come in, and it is often women in perinatal, you find that they're all quite maternal people. (India)

When thinking about why many staff members exude maternal traits, participants reflected that *'managers are really good at recruiting people with a very empathetic, compassionate perspective'*. The majority of participants also used the words *'perfectionists'* and *'rescuers'* to describe themselves and colleagues within their teams. Coupled with the perfectionistic rescuer traits, participants recognised that they can *'go above and beyond'* what is required of them because they want to *'offer perfect care'*.

Personal and professional traits, like perfectionism and a drive to ‘rescue’, may draw individuals to perinatal work but may also be shaped by systemic factors. These tensions between personal motivation and systemic constraint connect closely with how staff experience value and recognition in their roles, explored in the next theme.

Theme three: The importance of feeling valued

This theme highlights how appreciation from mothers and managers supports professional fulfilment.

Sub-theme 1: Feeling part of a team

Most participants described team containment and safety as improving their work. Many participants described an informal system of support, where colleagues whom they thought of as ‘friends’ helped with caseload management and emotional support. This reduced the emotional burden of their work, perhaps mirroring the containment they are providing to the mothers:

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)

Participants also emphasised managers’ roles in containment enabling effective work with this group of mothers. From a manager’s perspective, India spoke of putting supportive practices in place.

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’

Sub-theme 2: Reciprocal appreciation

Participants’ appreciation for mothers helped sustain investment in the work. Elizabeth spoke about what she admires in these women:

real sort of fun-loving characters underneath . . . there’s so much strength in them, so much resilience in them, 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.

Other participants reflected they find it ‘amazing’ to work with this cohort of women and how you witness their ‘resilience’. Participants described the women as ‘lovely’ and felt they could build strong rapport with them.

Theme four: Navigating a complex system

Despite the aforementioned positives, this theme describes systemic challenges impacting care.

Sub-theme 1: Having to be a ‘jack-of-all-trades’

Participants described role ambiguity and a lack of structured guidance when working with mothers diagnosed with EUPD, suggesting they find the work ill-defined:

Because if you asked me what piece of work is done with that lady in technical terms, I couldn't tell you . . . she was not in the kind of place where you do a structured piece of work and most of these women aren't sadly (Elizabeth)

Staff spoke about how this can leave them feeling '*useless*' as they want to be able to spend more time with these mothers but pressures within the perinatal service mean this is not possible. India further describes how this lack of definition can leave perinatal staff feeling:

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 one thing.

There was a sense of frustration when participants spoke about the ill-defined work for this cohort of mothers. These frustrations also linked to how staff understood diagnostic labels and the social narratives shaping their work, further discussed in theme five.

Sub-theme 2: The constraints of time

Alongside role ambiguity, participants reported insufficient time to deliver required care. Largely, participants discussed how they had not expected such high numbers of women with an EUPD diagnosis to need perinatal support:

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 (Charlotte)

The impact of time was discussed as contributing to the challenge of offering treatment and therapy, which practitioners felt there should be more of in the service. They said sometimes their treatment of these mothers had to be '*shorter*' than they wanted it to be, because there was '*not enough time*' to work with everyone on their caseload. The limitations of the service, in terms of available time and resources, often meant that the care fell short of what they thought was required to address the complexity of the women's needs. This reinforced feelings of letting mothers down, despite no fault of their own.

Theme five: Let's talk about labels

This theme explores how labels and social constructs shape care for mothers diagnosed with EUPD. Participants considered how services can '*lose empathy*' for women with this diagnosis because of preconceived ideas that people with EUPD are '*disordered, manipulative and dependent on services*'. Interestingly, participant Clare thought about the role gender plays in this distortion:

It's so far behind so many parts of medicine at the moment [EUPD diagnosis], 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 appears to question whether gender inequity is delaying diagnostic reform for this population. This is echoed by Charlotte, who criticises the focus on maternal mental health rather than a whole-family approach of perinatal services, reinforcing traditional gender roles that are often seen in society:

The perinatal model for me ... did a disservice to families because it was predicated on maternal mental health. Whereas we know when the baby arrives it's a family unit ... I think there's something about this is the mother's responsibility

Participants also considered class and socioeconomic status in how mothers are viewed. Participants observed how *'working class women'* are usually the ones to receive an EUPD diagnosis and that this means they are facing more socioeconomic instability whilst managing their distress. Participant Eden considers how this impacts mothers:

When someone doesn't have a stable base, or housing problems or financial worries and they're not stable in their relationship I think their symptoms are much more likely to be activated and prevalent in comparison to someone who has quite a comfortable home life

Participants felt that the negative view of women with an EUPD diagnosis was less pronounced in perinatal services because of their *'compassionate'* approach towards these women as mothers and that *'the service really understands the experiences of a person and what has led them to present in this way'*. An overwhelming thread within participants' language was the desire to use the term *'complex trauma'* in place of EUPD. These reflections on diagnosis and trauma inevitably raised questions about responsibility and service design, explored in the final theme.

Theme six: Where does the responsibility lie?

This final theme addresses systemic issues in perinatal provision for mothers with EUPD.

All participants discussed the lack of coordinated care between perinatal teams and Community Mental Health Teams (CMHTs) and how they felt perinatal caseloads were overburdened with women diagnosed with EUPD because CMHTs did not know how to work with this cohort of women:

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)

As a result, participants are having to *'educate'* CMHTs on the boundaries of perinatal provision. The lack of coordinated care between perinatal services and CMHTs was seen as a major contributing factor to the challenges faced by both service users and staff:

I would say with EUPD diagnoses ... we can't get them back into CMHTs once we've done our work and they're just waiting. They're just sitting on our caseload. We don't want to discharge them back to primary care because it's not appropriate but CMHT won't take them back. (Madeline)

Participants described how women with EUPD also seem to have been *'forgotten'* in perinatal service design and there was no specific funding to work with this group of women:

When our service was funded ... 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 meet this need. (Madeline)

Nearly all participants advocated for the creation of dedicated services for women with EUPD, recognising that general perinatal mental health services were insufficient for addressing their complex needs:

in my ideal world, I would like to sort of proportion some of the service as a dedicated service . . . So, for example offering a full DBT programme or a full MBT (mentalization based therapy) programme. (Charlotte)

Discussion

This is the first UK study to explore perinatal mental health staff experiences of supporting mothers diagnosed with EUPD. Staff described a strong commitment to trauma-informed, relational care, while negotiating tensions between empathy, professional boundaries and systemic constraints. To reflect this interplay and follow the sequence of findings, the discussion is organised around the six themes identified, tracing a trajectory from relational engagement to systemic responsibility. Findings highlight the need for trauma-informed, reflective and coordinated approaches that sustain both compassionate care and staff wellbeing.

Staff emphasised the importance of relational and trauma-informed approaches, describing their work as ‘walking alongside’ mothers rather than taking an authoritative stance. This mirrors attachment-focused practice, where consistency and containment are central to building trust. Several participants used attachment language such as ‘ghosts in the nursery’ (Fraiberg et al., 1975) to describe mothers’ efforts to break intergenerational cycles of trauma. These terms were introduced by some participants themselves, while the broader attachment framing reflects the researchers’ analytic interpretation. The relational intensity of perinatal work and staff’s empathy towards mothers striving to parent differently, highlight how social narratives around ‘good motherhood’ extend into the professional domain. This underscores the importance of recognising intersectionality and the sociopolitical context of women’s lives to fully understand their mental health needs.

Staff described the emotional intensity of supporting mothers with EUPD, recognising how traits such as empathy, perfectionism and maternal instincts shaped their practice. These qualities enabled compassionate care but also blurred boundaries and risked over-identification. Participants reflected on being pulled into maternal roles, echoing psycho-analytic ideas of projection and containment (Winnicott, 1994). Their ability to name and reflect on these dynamics illustrated strong reflective capacity. This emotional labour was both rewarding and exhausting, especially when systemic pressures limited time for reflection. Expectations to deliver more than good enough care mirrored societal ideals of motherhood, increasing burnout risk (Rose, 2019). Participants emphasised supervision and protected reflective spaces as essential to sustain empathy and wellbeing. Relational insight thus functioned as both a therapeutic tool and professional safeguard.

Participants emphasised how team cohesion and managerial support were central to sustaining compassionate care. Feeling valued by colleagues and managers mirrored the containment offered to mothers. Informal peer support and responsive leadership reduced emotional burden, aligning with evidence that collegial environments buffer burnout (Royal College of Psychiatrists, 2018). Staff also described reciprocal appreciation

from mothers, finding their resilience and humour deeply motivating. This mutual recognition reinforced professional purpose and offset stigma often associated with EUPD. However, when such validation was absent, staff reported greater emotional fatigue, underscoring the organisational need for protected supervision and reflective spaces to maintain relational safety (British Psychological Society, 2019). Valuing both staff and service users appears integral to sustaining trauma-informed care.

Participants described frustration at the lack of clear guidance when supporting mothers with EUPD. This role ambiguity reflected a broader absence of coordinated policy and service definition. Without structured pathways, staff felt responsible for needs that extended beyond their remit, creating what might be viewed as a systemic containment failure rather than an individual shortcoming. Flexibility to 'fill gaps' left practitioners feeling emotionally overextended. These tensions exemplify how blurred organisational boundaries contribute to burnout across the NHS mental health workforce. Perceptions of fragmented or undervalued work reinforced professional isolation, indicating the need for clear frameworks and integrated pathways to sustain staff confidence and continuity of care.

Participants reflected on how the EUPD label shapes empathy. Many felt that diagnostic language can obscure the impact of trauma, reinforcing stereotypes that women with EUPD are 'manipulative' or 'difficult'. Consistent with feminist critiques (Shaw & Proctor, 2005), staff questioned whether gendered and class-based assumptions contribute to the overrepresentation of working-class women among those diagnosed. This awareness highlights how structural inequities intersect with clinical discourse, shaping both diagnosis and access to care. Participants expressed a preference for the term 'complex trauma', viewing it as more compassionate and descriptive of lived experience. The shift in terminology appeared to foster empathy and more reflective practice, suggesting that language itself functions as an intervention. These reflections demonstrate how perinatal teams can resist stigma through relational, trauma-informed approaches that humanise mothers with EUPD. Recognising the sociocultural weight of diagnostic labels underscores the need for systemic accountability and coordinated care.

Participants consistently identified fragmented pathways and poor coordination between perinatal teams and CMHTs as major barriers to effective care. Many described supporting women who needed to be discharged from perinatal services but were not deemed eligible for CMHT support, creating role confusion and service strain. These accounts highlight how responsibility for mothers with EUPD is often displaced between services, reflecting a structural, not individual, failure of care. Staff advocated for clearer pathways and consistent inter-service communication to reduce this burden. Embedding trauma-informed approaches within commissioning structures could address these gaps by standardising training, supervision and referral processes. Models such as the new Maternal Mental Health Services in the UK illustrate how multidisciplinary, trauma-informed frameworks can improve coordination and relational safety (Benton et al., 2024; Easter et al., 2022). Aligning these principles with established NHS governance structures would also strengthen workforce wellbeing and promote sustainable, compassionate care. Addressing systemic accountability is therefore central to supporting both mothers with EUPD and the staff who work alongside them. Participants expressed the most emotion when discussing these systemic shortcomings, particularly the lack of integrated support from CMHTs. This may be because they do not have other outlets to

discuss service issues, but Zagier Roberts 1994 argues that teams often define themselves in opposition to others, fostering a ‘them and us’ culture. This may apply to perinatal services and CMHTs, with the former being considered a specialist service. Therefore, whilst participants’ concerns about CMHT pressures are valid, some reactions may reflect displaced frustrations that were easier to express than those related to clients. References to diagnostic displacement and rising caseloads reflect participants’ perceptions rather than formal audit data. Commissioning implications should therefore be read as experience-based insights, highlighting the need for systematic data collection to inform accurate service planning.

Strengths and limitations

Recruiting participants from three NHS Trusts strengthened this study by increasing the transferability of findings across perinatal mental health services in England, which follow broadly similar care pathways. The recurrence of key themes suggests that many of the issues identified are systemic rather than service-specific. However, transferability remains limited by the relatively small sample size. The challenge in recruitment reflects the time pressures repeatedly highlighted by participants, illustrating broader workforce constraints within the NHS (NHS England, 2019). A further strength lies in the first author’s reflexivity throughout the research process, including awareness of evolving assumptions and biases (Appendix B). This reflexive stance was integral to the analytic process and aligned with the principles of reflexive thematic analysis.

Most participants were white women, highlighting limited diversity within the sample. This restricts the transferability of findings, particularly given persistent inequities in maternal mental health outcomes among Black and Asian mothers (Draper et al., 2017; Knight et al., 2020). The absence of racially minoritised and male staff voices may also reflect gendered and cultural assumptions surrounding perinatal work. The views of men working in perinatal services are an important area to focus on as their experiences may contrast significantly to those of women, who are statistically more likely to be diagnosed with EUPD (Grant et al., 2010).

The exclusion of practitioners from mother-and-baby units and parent-infant mental health services was deliberate, due to smaller caseloads and variability of service designs across regions. However, this limits the analysis as experiences in these settings may differ substantially from those in community teams, especially in terms of funding and resources. Without integrated policies, perinatal teams may face disproportionate challenges managing mothers with EUPD compared to MBUs or PIMHs, a perspective not captured in this study.

Implications and recommendations

There is an urgent need for comprehensive audits within perinatal services to establish the prevalence of mothers diagnosed with EUPD. Without robust data, appropriate resource allocation remains difficult and commissioners may underestimate demand (NHS England, 2019). This study also highlights the need for clear, trauma-informed pathways. A trauma-informed pathway in perinatal services could include mandatory training in EUPD and relational approaches, such as

a 2-day accredited attachment-based programme (NHS Education for Scotland, 2017; Sweeney et al., 2018). Refresher workshops delivered annually for all clinical staff within existing CPD schedules would maintain competence while minimising disruption to service delivery. Following this, adopting a universal therapeutic framework, such as Compassion Focused Therapy (CFT), ensures consistent relational approaches across the team. CFT is well-suited to this work as it addresses shame and self-criticism common in EUPD (Gilbert, 2010). Implementation could align with existing NHS psychological governance structures. Clinical/Counselling psychologists already embedded in teams could provide supervision to ensure model fidelity. Outcome monitoring could use routine NHS metrics and patient-reported experience questionnaires to evaluate relational safety and compassion outcomes. Embedding CFT in this way would standardise therapeutic language and prevent model drift or duplication across teams. A scoping review found the UK amongst six European countries with comprehensive mental health policies and services, positioning it as a leader in the field (Sadeniemi et al., 2024). Therefore, changes in UK perinatal service design, based on staff experiences, could serve as models for replication across Europe.

Finally, sustaining this work for mothers diagnosed with EUPD requires attention to workforce wellbeing. Protected reflective spaces and supervision are essential to prevent burnout and maintain safe relational practice (Royal College of Psychiatrists, 2020), given the emotionally demanding nature of perinatal mental health work (Smith et al., 2023). Clinical Psychologists within perinatal teams are well placed to facilitate this support, given their expertise in helping teams process relational dynamics (British Psychological Society, 2019).

Future research

Future studies should include commissioners, service managers and diverse staff groups to identify broader changes that may be required. Specifically, male perspectives and staff from MBUs or PIMHs will help to fully map the ecosystem of perinatal EUPD care. International comparisons could also inform future service models by exploring how other countries support perinatal staff working with personality disorder presentations.

Conclusion

The provision of perinatal mental health services in England has significantly improved support for mothers diagnosed with EUPD, ensuring that many who previously received inadequate or no care now have their needs addressed. This study has explored the personal experiences of perinatal staff and their insights into providing perinatal care for mothers with EUPD. The findings highlight the perceived need amongst staff for service-level changes within perinatal services to deliver the most appropriate care for this group. Whilst reforms are needed, practitioners clearly value and derive meaning from this work, perhaps because a trauma-informed, attachment-focused lens helps humanise mothers with EUPD when they are often misunderstood.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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Appendices

Appendix A. First Author Reflexivity Regarding Coding

I debated coding in NVivo versus by hand before beginning analysis. Literature suggested either approach is acceptable, depending on researcher preference. Coding by hand initially felt overwhelming and I had previously used NVivo for smaller projects, so I began electronically, with the option to switch if needed. During theme development, however, I found viewing hundreds of codes on a screen unhelpful for visualising connections. I printed, cut and arranged codes manually which made the process more tangible and exciting, giving me something I could physically 'play' with when toying with different ideas and formations. The combination of electronic and manual methods allowed both efficiency and embodied engagement.

Appendix B. First Author Reflections

Completing this research highlighted and reshaped many of my biases. Despite my interest in working with individuals diagnosed with EUPD, I realised I had absorbed assumptions about how others perceived them. I expected participants to speak negatively, yet they described these mothers with compassion and insight. This contrast prompted guilt and reflection on how existing literature, which often emphasises pathology and difficulty, may have influenced my expectations.

The feminist framing of this study also deepened my understanding of systemic inequities. I became increasingly aware of how perinatal services, by design, focus almost exclusively on women. Participant discussions prompted me to question the gendered assumptions this reinforces, why responsibility for emotional labour and parenting support falls primarily on mothers and why services rarely engage fathers. This process heightened my awareness of the patriarchal discourses shaping mental health care and maternal responsibility.

These learnings will continue to influence me professionally and personally. Professionally, they emphasise how individuals with EUPD can become marginalised within fragmented mental health systems and how thoughtful, coordinated service design is essential. Personally, hearing participants' empathy and commitment has left me hopeful about the potential for compassionate, trauma-informed care. I hope these insights contribute to improving support for both mothers with EUPD and the dedicated staff who work alongside them.