



# Effectiveness of a brief parenting intervention for people with borderline personality disorder: a 12-month follow-up study of clinician implementation in practice

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## ABSTRACT

**Objective:** Borderline personality disorder exacerbates the everyday challenges of parenting and may lead to adverse consequences for both the individual and their family. This study is the first to evaluate the effectiveness of a brief parenting intervention for people with personality disorder using the perspectives of trained clinicians.

**Method:** The study used detailed retrospective qualitative and quantitative methods to evaluate clinician ( $n = 12$ ) implementation in real world settings over the first 12-months after being trained in the intervention.

**Results:** Clinicians were all using the intervention, predominantly as a module or sub-set of strategies within a larger treatment plan. Including the parenting intervention was associated with positive client outcomes across multiple areas of psychological functioning. Clinicians reported that the intervention was also effective at increasing their capacity to reflect upon parenting issues with their clients. Qualitative responses revealed three major themes: noticing client parenting improvement; improved clinician efficacy in conducting parenting interventions due to a manualised approach; and systemic improvement in work practices and attitudes to working with parenting aspects of treatment.

**Discussion:** Follow-up evaluation indicated that adding a parenting intervention to standard treatment improved parenting capacity for people with personality disorder, while simultaneously supporting clinicians' capacity to work with this clinical population. The findings contribute to an understanding of how clinicians' use interventions in practice and their effectiveness in an area that has the potential to reduce the impact of personality disorder on families.

## ARTICLE HISTORY

Received 1 September 2017

Accepted 11 April 2018

## KEYWORDS

Parenting; borderline personality disorder; intervention; intergenerational transmission; attachment

## Background

Implementation science recognises that a gap exists in the mental health field between what is known about effective treatment and what clinicians actually deliver (Tchernevski, Reupert, & Maybery, 2015). A recently published manualised parenting

intervention was the first to provide resources specifically targeted at parents with personality disorder (McCarthy, Lewis, Bourke, & Grenyer, 2016). The intervention, 'Parenting with Personality Disorder' is for parents who have a personality disorder, and provides treatment strategies targeting three key areas: child protection and family safety (including completing a family crisis care plan), improving communication between the parent and child (including skills in talking to the child about the parent's mental health and protecting the child from these symptoms), and improving parenting skills and strategies (including mindful parenting skills and reinforcing the primary importance of engagement in mental health treatment for the parent). The intervention can be delivered to parents as a stand-alone three-phase modular treatment, or to be used as an additional module added to a standard treatment for personality disorder. Details of the program are outlined elsewhere (McCarthy et al., 2016) but in summary, training in the brief intervention model involved the completion of 6 h of interactive skills training to ground attendees with the theory, research, and implementation of the intervention manual and approach. The program was designed for mental health clinicians involved in treating personality disorders.

An initial pilot study was conducted with 168 clinicians who voluntarily enrolled in the training program. A study of clinician acceptability found that training in the intervention improved clinicians' self-reported willingness, optimism, enthusiasm, confidence, theoretical knowledge and clinical skills in working with parents with personality disorder, with the majority of clinicians noting that the model would assist them in improving client outcomes (McCarthy et al., 2016). However, clinician acceptability of an intervention does not necessarily translate to effective use in practice (Damschroder et al., 2009). The personal characteristics of the clinician, as well as environmental factors, may impact the uptake of an intervention (Damschroder et al., 2009). Furthermore, the level of clinician understanding and confidence in using an intervention may also impact uptake and subsequent effectiveness (Grenyer et al., 2004; Neish, 2012). Clinicians are more likely to implement evidence-based practice when they have the appropriate level of competency, motivation, and opportunity within their workplace (Rousseau & Gunia, 2016).

Recent guidelines emphasise that 'having borderline personality disorder does not mean a person cannot be a good parent' (NHMRC, 2012, p. 3). Mental health care workers are therefore encouraged to recognise and support their client's parenting role (Reupert, Cuff, et al., 2012). To date, minimal research has been conducted on the effectiveness of parenting interventions specifically for personality disorder. Given that 6.1% of the population are thought to have a personality disorder (Huang et al., 2009) with many likely to be parents, this is a gap. Personality disorders are defined as an inflexible pattern of experience that deviates significantly from the expectations of the individual's culture (American Psychiatric Association, 2013). For the individual, personality disorder involves significant distress resulting from interpersonal difficulties, intense affectivity, impulsivity, and distorted cognitions (American Psychiatric Association, 2013). Such symptoms are likely to be expressed in the interpersonal context of the family, making early intervention that considers the interpersonal environment and potential impact on others a high priority. For the community, the severity and high prevalence of the disorder in turn places mental health services under pressure (Grenyer, 2014).

The difficulties of personality disorder can exacerbate the already challenging experience of parenting and lead to adverse effects for children (Bartsch, Roberts, Davies, & Proeve, 2015b). Parents with borderline personality disorder may experience impairments in expressing an empathic response, and the mental health problems can at times challenge them in providing a stable and safe environment, managing interpersonal boundaries, using parenting skills, and parental self-efficacy (Bartsch, Roberts, Davies, & Proeve, 2015a). These challenges appear to be additional to those experienced by parents with other mental illnesses (Bartsch et al., 2015b). Research has indicated specific difficulties include fluctuations between over and under involvement (Stepp, Whalen, Pilkonis, Hipwell, & Levine, 2012), an impaired sense of competence, and a need for positive reinforcement in their parenting behaviour (Ramsauer, Muhlhan, Mueller, & Schulte-Markwort, 2016).

Parents with personality disorder are also likely to have experienced childhood trauma, with prevalence rate estimates as high as 72% (Bierer et al., 2003). As such, parents may be experiencing post-traumatic symptoms triggered by the presence of their child (Newman & Stevenson, 2005). Moreover, their impaired ability to mentalise their child's perspective and preoccupation with the severity of their symptoms may be associated with difficulty separating their own needs from their child's (Fonagy, Target, Gergely, Allen, & Bateman, 2003). This can create an intergenerational transmission of trauma, resulting in an increased likelihood of children experiencing their own impairments in parenting and attachment patterns as adults (DeGregorio, 2013). Compared to a clinical sample of parents with a diagnosis of depression or another personality disorder, children of parents with borderline personality disorder were found to be at a greater risk of developing their own psychological problems (Bartsch, Roberts, Davies, & Proeve, 2016). Children may also experience a range of challenges including: behavioural problems, emotional and cognitive dysregulation, interpersonal difficulties and disturbed self-concept (Bartsch et al., 2015b).

Despite these challenges, the majority of parents will raise psychologically healthy children and should be encouraged in doing so (NHMRC, 2012). An increasing onus has been placed on health care workers to acknowledge their clients' parenting role and the needs of other family members, including children (Reupert, Maybery, & Kowalenko, 2012). This has led to the development of evidence-based interventions for families experiencing parental mental illness, including initiatives from the national Children of Parents with a Mental Illness Initiative (Fudge, Falkov, Kowalenko, & Robinson, 2004), the Circle of Security program (Marvin, Cooper, Hoffman, & Powell, 2002), and the Triple P Program (Phelan, Howe, Cashman, & Batchelor, 2012). A recent meta-analysis found that interventions to prevent mental health issues in children of parents with a mental illness appear to be effective, decreasing the child's risk of developing the same mental illness as their parent by 40% (Siegenthaler, Munder, & Egger, 2012).

The aim of this paper is to explore in depth the implementation of the Project Air Strategy's Brief Parenting Intervention for parents with personality disorder among a group of trained clinicians. A further aim is to gain their detailed subjective experience of the intervention in real-world settings. We were interested in whether the intervention translated effectively into practice, as indicated by their perceptions of the intervention and utilisation. Additionally, we aimed to study if the intervention improved client outcomes and clinician capacity to work with this historically challenging population.

## Methods

### *Participants*

The sample was drawn from a large pool of clinicians who voluntarily attended training in the Project Air Strategy's Parenting with Personality Disorder Intervention (McCarthy et al., 2016) in May 2015. An invitation for an in-depth interview was distributed to all clinicians 12-months post-training ( $N = 168$ ). The goal was to study a small sub-sample in depth using qualitative methods. The first twelve clinicians who identified themselves at the invitation as willing to discuss the implementation of the intervention within the timeframes of the study were chosen. Once this convenience sample was identified further follow-up with other trained clinicians did not occur.

### *Data collection*

Participants provided informed consent following Human Research Ethics Committee approval of the study. Follow-up interviews used a structured, mixed-methods design, exploring participant experience with the intervention. These questions were designed in collaboration with senior researchers. Interviews were audio-recorded with participants' consent.

Several ratings were obtained from participants. First, they were asked to self-report their level of expertise in treating personality disorders (rated as either minimal, developing, sound, advanced, or expert). Second, participants were asked to rate their willingness, optimism, enthusiasm, confidence, theoretical knowledge and clinical skills for working with people who have personality disorders on a ten point scale (extremely low to extremely high). Using the same scale, participants rated their understanding and confidence in using the parenting intervention, their willingness to incorporate the intervention into their practice, as well as the flexibility, usefulness, and benefits of the intervention. Third, participants rated how effective the intervention was at assisting them to reflect on parenting issues on a ten point scale (not effective at all to completely effective). Fourth, the use of the intervention was coded as a binary variable with participants answering yes or no to whether they had used or recommended a resource (for example, the educational video or factsheets) or as a standalone brief intervention. Lastly, clinicians were asked to reflect on their experience of using the intervention with one particular client. To gain an understanding of the client's functioning prior to the intervention, participants were asked to rate the following on a scale of one to ten (one being extremely low, ten being extremely high): the amount of time spent discussing parenting, the clients' apprehension about discussing parenting issues, and the client's willingness to engage with the intervention. Participants also rated their client's level of improvement on a ten point scale (no improvement to total improvement) in the following areas: general mental health functioning, willingness to discuss parenting, parental self-efficacy, ability to separate parenting from their disorder, ability to positively interact with their family members, and cooperation in therapy.

### *Data analysis*

Descriptive analyses explored the clinicians' expertise in treating personality disorders; attitudes towards personality disorder; use of the intervention and effectiveness of the

intervention, as outlined in detail above. Clinicians responded to several open ended questions: aspects of the intervention liked by clinicians; identified improvements to the intervention; clinicians' experience using the intervention with a particular client; parenting issues explored with the intervention; and barriers to intervention utilisation. Qualitative data were professionally transcribed and managed by QSR NVivo version 11 (QSR International, 2015). An inductive approach underpinned by realist principles was used. The development of themes followed a process described by Braun and Clarke (2006). The initial 20 per cent of open-ended question responses were coded by two raters (AG and MT) (inter-rater reliability = 90% agreement) to understand the key themes identified by clinicians regarding the intervention. Given the strong inter-rater reliability value in the initial 20 per cent, the remaining 80 per cent were coded by the first rater (AG). After coding was complete, the same second rater reviewed the codes for any disagreement or discrepancies, which were then discussed and resolved by agreement.

## Results

### Participants

Clinicians ( $n = 12$ ) were predominantly female ( $n = 8$ , 67%), with an average age of 42 years ( $SD = 12.48$ ). Staff professions included psychologists ( $n = 9$ , 75%) and nurses ( $n = 2$ , 17%), with one clinician identifying themselves as a mental health worker. Most clinicians ( $n = 9$ , 75%) were working in a community mental health setting delivering psychological treatments to community clients with mental health disorders. The remaining clinicians worked in an inpatient or rehabilitation setting ( $n = 2$ , 17%), while one clinician's work setting was not specified. Most clinicians rated their level of expertise with working with people with personality disorder as sound ( $n = 7$ , 58%) and advanced ( $n = 4$ , 33%). Only one clinician rated their expertise as developing. Two clinicians noted that they were currently using Dialectical Behaviour Therapy (DBT) with their clients.

We were interested in how representative this sample of 12 resembled the full training sample. In comparison to the original training sample ( $N = 168$ ) from which the participants were drawn those included here did not significantly differ on gender ( $\chi^2 = 2.77$ ,  $p = .096$ ), age ( $U = 975$ ,  $Z = -.122$ ,  $p = .903$ ) or expertise ( $U = 705$ ,  $Z = -1.78$ ,  $p = .075$ ).

Participants rated their understanding of the intervention ( $M = 7.25$ ,  $SD = 1.54$ ), confidence in using the intervention ( $M = 6.92$ ,  $SD = 1.08$ ), and willingness to engage with the intervention ( $M = 7.75$ ,  $SD = 1.71$ ) as considerably high. The perceived flexibility ( $M = 7.58$ ,  $SD = 1.73$ ), usefulness ( $M = 8.00$ ,  $SD = 1.48$ ), and benefits ( $M = 8.17$ ,  $SD = 1.47$ ) of the intervention were also rated highly. Participants reported high ratings of attitudes towards the treatment of personality disorders, with higher scores indicating a more positive attitude (see Table 1).

### How the brief intervention was used

Exploration of participants' use of the intervention over the 12-month implementation period indicated that they mostly used it embedded within an ongoing treatment i.e. as one module of an existing therapy. Only one had used the intervention as a stand-alone

**Table 1.** Mean clinician attitudes toward personality disorders (SD).

Attitude	<i>M (SD)</i>
Willingness to work with people with personality disorders	9.08 (1.00)
Optimism in working with people with personality disorders	8.17 (1.19)
Enthusiasm in working with people with personality disorders	8.42 (0.79)
Confidence in working with people with personality disorders	7.25 (1.36)
Theoretical knowledge about people with personality disorders	7.17 (1.27)
Clinical skills in working with people with personality disorders	7.17 (1.27)

Note.  $N = 12$ . Rating scale range 1–10.

intervention, without any additional treatment with the parent. Qualitative information revealed that the clinician's work settings often did not provide opportunity to use the resources as a stand-alone intervention. Reasons for this included not having a client who only required parenting skills alone, rather than in combination with ongoing care, or only having a limited number of sessions with a client meaning parenting skills needed to be integrated into a brief treatment. In relation to the different components of the intervention, the factsheets, clinical resources, or the video, all clinicians had used at least one component. Of this total, 11 watched with or recommended the parenting video to clients, ten used or recommended the factsheets, and seven used other clinical resources such as the family care plan.

### **Impact of brief intervention on clients**

Participants were each asked to identify one client and to reflect on the changes observed. Importantly, participants choose clients who were ready to engage in a parenting intervention. Client's level of apprehension for discussing parenting issues in therapy was rated as low ( $M = 3.44$ ,  $SD = 2.92$ ) and willingness to engage with the intervention as quite high ( $M = 6.78$ ,  $SD = 2.68$ ). Clinician reported ratings of client improvement were obtained in relation to benefits from the parenting component, and are reported in Table 2, suggesting acceptable improvement in multiple areas of functioning after engaging with the intervention.

### **Thematic analysis**

Three themes were identified by clinicians in discussing the implementation of the intervention: noticing client parenting improvement; improved clinician efficacy in conducting parenting interventions due to availability of manualised approach; and systemic improvement in work practices and attitudes to working with parenting aspects of treatment.

**Table 2.** Mean ratings of client improvement from the parenting intervention (SD).

Statement	<i>M (SD)</i>
Rating of improvement in general mental health functioning	5.00 (2.83)
Increased willingness to discuss parenting in therapy sessions	6.22 (3.07)
Improvement in general parental self-efficacy	6.22 (1.86)
Greater ability to separate parenting from their personality disorder	5.00 (2.87)
Greater ability to positively interact with their family members	6.38 (2.50)
Improvement in cooperation in therapy	6.56 (2.60)

Note: Rating range 1–10 from no to total improvement.

Table 3 presents significant statements and their formulated meanings, followed by detailed descriptions of each theme.

### **Theme 1: Noticing client parenting improvement**

Clinicians described various ways that clients had improved, after the intervention. The following sub-themes reflect the key areas of improvement: 1) mindful parenting, 2) de-escalated reactivity in the family unit, and 3) normalising parenting challenges.

*Mindful parenting.* According to clinicians, the intervention facilitated clients' capacity to reflect on their parenting role and how parenting interacts with their personality disorder. Improvements in the client's ability to be present in the moment with their child was facilitated by the intervention's resources: 'When mum's feeling really overwhelmed and she's not able to connect with the children in that moment, the Project Air concepts about being mindful and present have helped reframe that.' Being able to separate their parenting role from their mental illness was also noted, along with improvements in meeting their child's needs, being persistent in their parenting role, and connecting with their child.

*De-escalated reactivity in the family unit.* Clinicians noted that the intervention aided their clients' understanding of their emotions and reduced emotional reactivity within the family unit. One clinician stated: 'I've drawn on the Project Air manual about how to communicate and de-escalate highly emotional situations. I've adapted it and made it conversational. I think that's been received really well.'

*Normalised parenting challenges.* An emphasis was placed on the normalising effect that the intervention had, with clients realising that they were not alone in their parenting challenges: 'It's a good way of bringing it [parenting] up, normalising it and saying, 'look, this is not something that only you experience.'"

### **Theme 2: Improved clinician efficacy in conducting parenting interventions due to a manualised approach**

The treatment manual included an educational video, factsheets and resources that were a central focus of discussion in therapy. Participants mentioned that the approach normalised the client's experience and guided parenting discussions to be non-confrontational and empathic. Moreover, clinicians commented that the manualised approach was

**Table 3.** Significant statements and their formulated meanings.

Significant statements	Formulated meanings
a. 'Getting the family plan and putting that into place ... I think she felt validated and heard.'	a. The intervention normalised and validated the client's experience.
b. 'The video was really powerful.'	b. The parenting video was particularly useful in supporting clients.
c. 'Its philosophy: Coming from that stance that people with personality disorder can make good and that they do make good parents.'	c. Clinicians valued the key principles and philosophy of the intervention.
d. 'It gives you that permission to raise parenting with parents with a mental illness.'	d. The intervention assisted clinicians' capacity to discuss parenting issues.
e. 'It has given my own professional practice that fine tuning with the approach to people with these presentations.'	e. The intervention improved clinicians' work practices.
f. 'I think one of its big powers was in being able to change attitudes.'	f. The intervention shaped attitudes towards personality disorder treatment.

received well by the client and facilitated their improvement in multiple areas. This is highlighted in the following participants' comments:

"Having the video tool to use as a discussion point."

"I've overwhelmingly had families come back and say 'Those sheets you gave me were really helpful', and that's always specifically related to the Project Air factsheets."

### ***Theme 3: Systemic improvement in work practices and attitudes to working with parenting aspects of treatment.***

Clinicians reported that the intervention helped shape work practice and attitudes more broadly within their workplace and systemic context, particularly towards the discussion of parenting issues and decreasing stigma towards personality disorders. This theme was divided into three sub-themes: (1) philosophy of the intervention, (2) improved awareness and reflection of parenting challenges and (3) enhances current therapy.

*Philosophy of the intervention.* Philosophy refers to the key principles of the intervention that clinicians noted as being valuable to the success of the intervention. This included the non-judgmental attitude towards parents with personality disorder and the emphasis on compassion: 'It doesn't make judgements about parenting, it just offers guidance.' This theme was also apparent in clinicians' use of the intervention, with clinicians noting that they could use the intervention philosophy broadly and systemically within their workplace as well as applying the key principles as a stand-alone parenting intervention.

*Improved awareness and reflection of parenting challenges.* The intervention facilitated clinicians' capacity to reflect on parenting challenges for people with personality disorder. Clinicians mentioned that the intervention provided them with an opportunity to talk about parenting in a simple and non-confrontational manner. The idea that the intervention gave clinicians 'permission' to discuss parenting issues was also noted.

*Enhances current therapy.* Clinicians suggested that the intervention's flexibility allowed them to incorporate it into their current therapeutic commitments, either as a starting point or adjunct. Participants noted that the intervention was: 'Used as an adjunct to longer term therapy' and that 'Within DBT I can incorporate parenting because the factsheets are skills-based.' These developments lead to system-wide and institutional opportunities to change practice and re-think good practice.

## **Discussion**

The present study was a 12-month longitudinal follow-up of clinicians use in practice of a new brief intervention for parents with personality disorder. Clinicians predominantly included the intervention as a component within a broader treatment plan. Only one clinician had used the resources as a standalone intervention. This reflects the reality of intervention use in practice (Damschroder et al., 2009; Tansella & Thornicroft, 2009). The literature highlights that the most beneficial parenting interventions for mothers diagnosed with BPD are those theoretically consistent with their current individual treatment (Linehan, 1993; Zalewski & Lengua, 2012). Interestingly, a study investigating women's experience of parenting with BPD found that clients wished parenting was incorporated into DBT (Zalewski, Stepp, Whalen, & Scott, 2015). In the present study, clinicians

reported a similar experience, noting that they were able to incorporate the intervention modules into their current treatment modalities, such as DBT, suggesting the intervention's flexibility was an advantage.

Clinicians reported the manualised intervention contributed to the improvement of multiple areas of client psychological functioning. Such findings are in-line with past research demonstrating that interventions for parents with a mental illness are effective in supporting parenting capacity and improving outcomes for the family unit (Reupert, Cuff, et al., 2012; Siegenthaler et al., 2012). The intervention also improved outcomes for the clinician, with clinicians noting that the intervention was effective in assisting them to reflect on parenting challenges (Tchernegovski et al., 2015). These findings support the results of McCarthy et al. (2016), suggesting that clinicians' high acceptability of the intervention post-training indeed translated into effective outcomes for both the client and clinician longitudinally.

In-depth analysis of interviews revealed that clinicians felt that the intervention facilitated client improvement in multiple areas of functioning. For example, it offered mindful parenting strategies, de-escalated reactivity in the family unit, and normalised their parenting experience. Moreover, clinicians valued the manualised approach that included rich clinical tools including videos and factsheet resources. These contributed to the intervention's overall flexibility and accessibility. Lastly, clinicians noted that the intervention improved their work practice and attitudes within their team more broadly. This theme was related to the philosophy of the intervention and its ability to complement their current practice and shape attitudes towards people with personality disorder. These themes aligned with clinicians' quantitative ratings, which indicated improved clinician capacity to work with this clinical population and associated improvements in client functioning. These findings reinforce the existing literature on the effectiveness of brief interventions for parents with other mental illnesses (Solantaus, Paavonen, Toikka, & Punamaki, 2010).

We report a number of limitations. First, the study represents the views of 12 clinicians only; further research on larger samples is needed to replicate the findings reported here. The sample studied here did match the characteristics of the larger trained cohort ( $N = 168$ ), but how other clinicians were using the intervention is not known. We found saturation of themes in the thematic analysis, mirroring the recommendation that 12 participants are generally required before a saturation of themes becomes evident (Guest, Bunce, & Johnson, 2006). The mixed methods approach overcame some of the limitations of a small sample size, by providing rich data to explore in more detail how clinicians were noticing the relationship between the intervention and difficulties in the family functioning being worked through in treatment. It is also interesting to note that most used the intervention within an existing treatment, meaning it was difficult to separate the effects of the parenting work from broader improvements occurring across treatment. Future research may consider larger evaluations including dismantling studies or randomised trial designs (with or without parenting skills). A final limitation was our focus on the clinician as participant; we did not have the opportunity to discuss outcomes directly with patients, which would be recommended in future studies.

In conclusion, clinicians readily incorporated a manualised parenting intervention within their current treatment for people with personality disorder. All clinicians studied had implemented aspects of the manualised parenting program within the 12-

months follow-up post-training. They reported the outcomes of the approach to be highly effective and meaningful with people with personality disorders who were also parents. The intervention assisted clinicians to add structure around conversations related to parenting, helped them implement effective strategies to improve skills and mental health, and the intervention modules resonated with the difficulties clients were facing in treatment and provided practical tools to assist them improve the family environment.

## Disclosure statement

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

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