Attitudes Towards Parents with A Diagnosis of Borderline Personality Disorder

This thesis is submitted in partial fulfillment of the Honours degree of Bachelor of Psychological Science (Honours)

Word Count: 9,279

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Abstract

Borderline personality disorder (BPD) has been linked to dysfunction in interpersonal skills, which can extend to parent-child relationships. Parents diagnosed with BPD are found to have higher rates of child protection involvement in comparison to laypeople, likely due to the dysfunction in interpersonal skills, as well as emotional and behavioural dysregulation, and impulsivity. However, there is little evidence examining whether this is due to the behaviour of the parent, or the attitude of the worker assessing the capability of the parent. Research has shown that BPD carries a significant amount of stigma. Stigma is especially problematic for individuals with BPD as they can view this distancing as rejection, which can cause them to react negatively, further perpetuating the symptoms and thereby the stigma. As there are little known standardised procedures for parenting capacity assessments (PCAs) within the child protection sector, the likelihood of stigma contributing to the decision-making process is high. This study aimed to examine this using a set of vignettes (one with BPD vs one with post-natal depression) followed by a PCA adapted from previous literature, and multiple measures examining participants attitudes towards BPD. The sample included current, past and prospective child protection workers. The results show that stigma is significantly associated with BPD, and that stigma is heavily associated with treatment optimism. However, overall attitudes of BPD do not have a significant impact on stigma relating to BPD. Interestingly, there were a wide range of differences between professionals, and prospective workers, indicating experience also effects stigma.

Keywords: borderline personality disorder, child protective services, parenting capacity assessments, stigma, mental illness

Declaration

This thesis contains no material which has been accepted for the award of any other degree of diploma in any University, and, to the best of my knowledge, this thesis contains no material previously published except where due reference is made. I give permission for the digital version of this thesis to be made available on the web, via the University of Adelaide's digital thesis repository, the Library Search and through web search engines, unless permission has been granted by the School to restrict access for a period of time.

Contribution Statement

In writing this thesis, my two supervisors and I collaborated to generate research questions of interest and design the appropriate methodology. I conducted the literature search, completed the ethics application and preregistered the project. My two supervisors and I collaborated in selecting vignettes, designing the survey and uploaded it into Qualtrics. I was responsible for all participant recruitment and testing. I conducted analyses in SPSS, with the guidance of my supervisors, and wrote up all aspects of the thesis.

Attitudes Towards Parents with A Diagnosis of Borderline Personality Disorder

Borderline Personality Disorder (BPD) is a complex and severe mental illness, where the individual experiences distress which can include impulsivity, emotional dysregulation and disordered cognitions (American Psychiatric Association [APA], 2013). BPD often involves difficulties in intrapersonal (e.g., self-worth, identity, self-direction), and interpersonal functioning (e.g., ability to build and maintain close relationships, as well as the ability to understand others' perspectives) making it difficult to manage or dissolve conflict (APA, 2013). Interpersonal dysfunction may also include difficulty trusting others and hypervigilance to abandonment within close interpersonal relationships (Lazarus et al., 2014). For those diagnosed with BPD, symptoms such as high levels of impulsivity and emotional dysregulation may lead to self-harm, substance abuse and suicide (APA, 2013).

The prevalence of BPD globally estimates a range from 0.5 to 1.6% and 0.95% in Australia specifically (Coid et al., 2006; Jackson & Burgess, 2000; Lenzenweger et al., 2007; Samuels et al., 2002; ten Have et al., 2016; Torgersen et al., 2001). According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM; APA, 2013), up to 75% of those given a diagnosis in the United States are female based on research within clinical populations. However, in the general population, BPD appears to occur equally among men and women (Gunderson et al., 2013). Research suggests that women may be more likely to be referred to or seek professional help (Ronningstam et al., 2018). Sansone and Sansone (2011) suggested that this may be due to gender stereotypes and clinician bias towards diagnosing women with BPD.

Twin studies have shown genetic heritability of BPD ranging from 37-69% (Bornolvalova et al., 2009; Distel et al., 2008; Kendler et al., 2011; Torgersen et al., 2008; Torgersen et al., 2000; Torgersen et al., 2012). Negative early experiences with parents and caregivers, in combination with genetic vulnerability, may be a major risk factor in

developing BPD (Stepp et al., 2016). Extended twin studies have reported that gene-environment interactions are associated with the development of borderline personality traits and symptoms (Distel et al., 2011), indicating life events and genetics may be equally significant in the development of BPD. In other words, the parent-child relationship is an important factor when considering BPD, specifically when considering intergenerational transmission contexts (Steele et al., 2020).

Parenting and BPD

Researchers report that parents with BPD may experience additional challenges in their parenting role i.e., as they experience difficulties expressing appropriate empathic responses and interpersonal conflicts in addition to the lack of ability to resolve, these symptoms can exacerbate the everyday challenges of being a parent (Barnow et al., 2006). Steele and colleagues (2020) examined parental variables including stress and competence levels among parents with BPD through a composite self-report measure of stress and competence derived from several questionnaires. The findings demonstrated that mothers with BPD experienced perceived feelings of distress and incompetence relating to their parenting (Steele et al., 2020). These feelings of distress and incompetence may inadvertently affect parenting capacity and lead to difficulty engaging in safe parenting for their children (Newman et al., 2007). Similarly, feelings of emptiness from the parent may result in lack of attentiveness or vacancy in emotion within the parent-child relationship (Bartsch et al., 2016). Interestingly, mothers with depressive disorders have been found to have similar emotional relatedness and attentiveness to their children as mothers with BPD (Barnow et al., 2006). Many (some studies have shown up to 84%; Zanarini et al., 2002) individuals with BPD describe experiences of emotional abuse and/or neglect before the age of 18, highlighting the potential impact of early life experience as well as increased risk of intergenerational transmission. Research suggests that a parent's history of early trauma may be associated

with negative outcomes for their children. Furthermore, the parent-child relationship may trigger painful memories of trauma from the parents' own childhood and thereby be associated with feelings of incompetency and higher stress levels (Barnow et al., 2006).

Interpersonal dysfunction in BPD may also extend to the parent-child relationship due to the behavioural learning of children and attachment organisation (Bartsch et al., 2015b). Symptoms of interpersonal dysfunction involve having a distorted self-image, an unstable sense of self, and cognitive dysregulation, which may negatively impact the child's self-image as they develop (Bartsch et al., 2015a). A secure attachment in a parent-child relationship is said to be an important foundation in early childhood for developing secure and healthy attachments in adolescence and adulthood (Bowlby, 1969). According to attachment theories, infants have an innate need to be in close proximity to their caregiver or parent to ensure emotional and physical security (Bowlby, 1969). In other words, the infant needs the parent or caregiver to feel safe in unfamiliar surroundings which allows them to feel comfortable in exploring the world. Attachment theories propose that sensitivity, relatedness and responsiveness to the infant influence the development of attachment patterns (Bowlby, 1969). If the child's attachment needs are not met in the early development stages, they may develop maladaptive patterns of self-regulation which result in insecure attachment, and thereby influence their future relationships and self-image (Bowlby, 1969; Fonagy et al., 2000).

Researchers have found that individuals with BPD are more likely to exhibit insecure attachment styles than the general population (Agrawal et al., 2004). Research shows that mothers with a diagnosis of BPD are more likely found to have infants who also exhibit insecure (or disorganised) attachment patterns (Hobson et al., 2005), suggesting that insensitive maternal relatedness is a key factor impacting attachment organisation of infants. The literature suggests that the quality of a parent's relatedness to their child is influenced by

their own psychological wellbeing and their sense of self (Barnow et al., 2006; Hobson et al., 2009; Newman et al., 2007). It has been proposed that perceived parenting stress and incompetence, in addition to fear of abandonment and emotional dysregulation, contribute to the quality of parental relatedness within the parent-child relationship, which may then affect the attachment pattern of the child (Steele et al., 2020). Furthermore, given parenting is bi-directional, a child with a difficult temperament may be an additional stressor for a parent with a diagnosis of BPD (Ben-Porath, 2010). Therefore, further contributing to the possibility of intergenerational transmission cycle of BPD.

The potential impact of a parental diagnosis of BPD on children can occur across different developmental periods. Research has suggested that infants of parents with a diagnosis of BPD are more likely to have disorganised attachment, poorer emotional regulation, reduced eye contact and lowered infant affect (Eyden et al., 2016; Hobson et al., 2005; Petfield et al., 2015). Young children of parents with a diagnosis of BPD (aged 4-14) were more likely to have a less stable self-image, higher emotional dysregulation and more negative parent-child experiences (MacFie & Swan, 2009). One study found that children aged 6-14 were significantly more likely to meet diagnostic criteria for depression (Abela et al., 2005). Adolescents of parents with a diagnosis of BPD have reported greater psychopathology (e.g., nervous, shy in social situations, inhibited), more emotional (e.g., anxiety/depression), behavioural (e.g., delinquency or aggression) and interpersonal problems, as well as higher levels of suicidal tendencies (Barnow et al., 2006).

Compared to the general population, parents with BPD and elevated borderline symptoms have been found to be associated with higher rates of child abuse potential (Dittrich et al., 2018; Herron & Holtzworth-Munroe, 2002; Hiraoka et al., 2016), child protection involvement (Blankley et al., 2015; Laulik et al., 2016; Perepletchikova et al., 2012), hospitalisation, and incarceration (Carlson et al., 2009; Crawford et al., 2009). As

there is a clear oversaturation of mothers with a diagnosis of BPD (or fit the criteria) involved with child protective services, it is important to explore what may be the cause of this. While it can be drawn from the current literature that there is a potential child protection risk for parents with BPD, there is a gap in the literature exploring the decision-making process and how much effect stigma has on these decisions.

Stigma Associated with BPD

Unfortunately, there is a long history of stigma existing towards people diagnosed with psychiatric illnesses within society (Johnstone, 2001; Overton & Medina, 2008; Byrne, 2000). Byrne (2000) defined stigma as "a sign of disgrace or discredit, which sets a person apart from others" (p. 65). Society, as a whole, has difficulty separating an individual from the psychiatric illness or manifestations that they are afflicted with (Byrne, 2000). This inability to separate the individual from their illness can be due to societies idea that the illness has control over the person's actions and behaviours (Ring & Lawn, 2019). Corrigan et al. (2014) stated that "understanding stigma is central to reducing its negative impact on care seeking and treatment engagement" (p. 37). By providing psychoeducation, people have a better understanding of the stigmatised group, allowing them to diminish any preconceived ideas (Ahmed et al., 2021). Ring and Lawn (2019) stated that stigma associated with BPD may be reduced when there are higher levels of empathy, and better knowledge of the disorder. Without understanding stigma or the disorder, a dialectical relationship is formed. For example, the symptoms of the illness create stigma aimed towards the individual, thereby exacerbating the illness and isolating the individual further, and limiting their access to support in place to help reduce symptoms (Ring & Lawn, 2019). Therefore, stigma and mental illness feed into a vicious cycle that have been found to have detrimental effects for people (Ring & Lawn, 2019). BPD is theorised as having more stigma associated with it compared to other mental illnesses (Aviram et al., 2006; Klein et al., 2021). Due to the

unpredictability of behaviour and intense range of emotions, it may be difficult to differentiate the nature of the illness from the nature of the individual. If the latter occurs, the individual is more likely to be condemned within society (Rivera-Segarra et al., 2014).

Individuals diagnosed with BPD have been described as difficult to fully engage in treatment, despite frequent use in services (Bodner et al., 2015; Ring & Lawn, 2019). Stigma has largely been associated to this. Aviram and colleagues (2006) argued that health professionals tend to hold negative assumptions about treatment effectiveness with people diagnosed with BPD. Kelly and May (1982) theorised that stigma within health services is based on feelings of helplessness from professionals. However, it has been found that health professionals in mainstream services feel uncomfortable in working with individuals diagnosed with BPD (Aviram et al., 2006; Knaak et al., 2015). Ring and Lawn (2019) stated that this is due to the idea that individuals diagnosed with BPD are manipulative and non-compliant with the healthcare system. This has arguably led to these individuals feeling ostracised, and likely heightening their experiences of exclusion. Therefore, they may be less likely to fully engage in treatment due to fear of judgement and/or rejection (Ring & Lawn, 2019). Individuals with BPD often carry a significant burden of shame, relating to the stigmatising views towards the diagnosis. Previously, individuals within the health-care system who were viewed as problematic, and manipulative were diagnosed with BPD (Gunderson, 2009; Knaak et al., 2015). Therefore, historically, the legitimacy of the illness has been questioned within the healthcare system (Gunderson, 2009).

Day and colleagues (2018) investigated attitudes of mental health staff towards patients diagnosed with BPD from 2000-2015. It was found that the 2015 sample focused more heavily on treatment approaches and had more positive attitudes towards the patients, which may reflect greater awareness and use of treatment that has developed toward the diagnosis over the last 20 years. Therefore, the attitudes of health care professionals and the

general environment has begun changing, however BPD still carries heavy stigma from its history (Bodner et al., 2015; Klein et al., 2021; Ring & Lawn, 2019). In a large study surveying qualified mental health professionals, nearly half reported they preferred to avoid patients diagnosed with BPD (Black et al., 2011). Interestingly, nurses scored lowest on overall caring, while social workers scored highest. Social workers and psychiatrists scored highest on treatment optimism, while nurses scored lowest on treatment optimism and empathy. However, scores were higher on all measures, for clinicians who had recent experience working directly with patients with a diagnosis of BPD compared to those who did not (Black et al., 2011). Another study found psychiatric nurses had more negativity, less sympathy and less optimism toward patients with BPD, compared to patients diagnosed with schizophrenia or depression (Markham, 2003). BPD patients were also perceived by nurses as more dangerous, therefore the nurses were more socially rejecting toward them.

Ring and Lawn (2019) proposed that stigma associated with BPD may be maintained through poor health literacy on the illness, and through health professionals deferring the responsibility onto others, stalling engagement with treatment, and disempowering patients. A number of authors have recommended more targeted education, advocacy and leadership in order to help address the stigma (Bodner et al., 2015; Klein et al., 2021; Knaak et al., 2015; Ring & Lawn, 2019). Similarly, Aviram and colleagues (2006) investigated stigma associated with BPD and found that in society, people tend to distance themselves from stigmatised populations. This distancing can be especially problematic for people with BPD due to their oversensitivity to rejection and abandonment. If distancing or rejection is perceived, the individual may react negatively by harming themselves or withdrawing from treatment (Aviram et al., 2006). In other words, the stigma influences the clinician's reactivity, thereby exacerbating the same negative behaviours that influenced the stigmatising views of the clinician, creating a self-fulfilling prophecy and a cycle of stigmatisation in which all parties

contribute. Given that people with a diagnosis of BPD or elevated borderline symptoms report experiencing greater stigma and that research indicates treatment providers and health professionals view this population more negatively, it is possible that child protection workers may also be influenced by negative attitudes, particularly during the decision-making process, when evaluating ones parenting capacity.

Child Protective Services

BPD and/or elevated borderline symptoms have been associated with child protection involvement. A recent study of children involved with child protective services for history of maltreatment, substance abuse, and family violence reported that in a sample of 1875, 34.3% of mothers had a diagnosis or met the DSM criteria for BPD (Laporte et al., 2018). Half of the mothers in this study had also experienced childhood maltreatment in their early childhood and had contact with child protection themselves when they were children (Laporte et al., 2018), which suggests a perpetuating cycle of child protection involvement. Furthermore, symptom characteristics of BPD (e.g., difficulty managing emotions such as anger), can result in harsher punishment, maternal hostility toward the child and negative expressed emotion (Hallquist et al., 2015; Stepp et al., 2014; Wolke et al., 2012). A combination of these outcomes, along with behavioural dysregulation (e.g., impulsivity and suicidal behaviour), may make it difficult to maintain a safe and secure environment for a child. Social learning theory suggests that children replicate behaviours learned from their parents, exposing them to risk of adopting the same behaviours (Bandura & Walters, 1977). Additionally, it has been proposed that some women with BPD are unmarried and at higher risk of choosing violent and abusive partners, further contributing to the difficulty in maintaining a stable environment for their children (Laporte et al., 2018).

Laporte et al.'s (2018) study found that caseworkers under-reported and under-recognised the presence of BPD. This could be due to the lack of training child protection

workers have in identifying diagnoses, and investigations by child protective workers did not involve an in-depth assessment of parental functioning (Laporte et al., 2018). Laporte et al. (2018) also found that mothers with BPD were at further risk of losing (full or partial) custody of their children, further perpetuating the cycle of child protection involvement. Without the ability to recognise and identify diagnoses, social workers may unknowingly contribute to the self-fulfilling prophecy of stigma and potentially preventing mothers with BPD from seeking professional help. Stanley et al. (2003) reported that due to their pessimistic view towards the parental abilities of mothers with BPD, social workers tend to place children of parents with a diagnosis of BPD into out-of-home care more quickly. Meaning that stigma may play a role in the high saturation of mothers involved in the system, that have been diagnosed with BPD. However, to-date, no studies have specifically assessed child protection workers attitudes towards parents with a diagnosis of BPD, which is the basis of the research aims for the current study.

Interestingly, there is no international standardised procedure regarding out-of-home placement decisions within the child protection sector to the authors knowledge. Specifically, guidelines for child protection workers assessing and working with parents with a mental illness, particularly BPD, are generally lacking. There is a growing body of research dedicated to understanding the decision-making process, however agreement between professionals in this area has been low, which suggests the process is predominantly based on the opinion of the worker (de Haan et al., 2019). Research has shown that majority of professionals were more child focused than family focused, meaning they were more likely to place children in out-of-home care, rather than requesting services be provided to the family (Britner & Mossler, 2002). Studies have indicated that students, who lack experience, evaluated information relating to the abuse or neglect of a child more systematically and were more likely to directly implement decisions based off limited information, compared to

qualified social workers (Davidson-Arad et al., 2003; De Ruiter et al., 2013). However, other studies have reported no difference between students and professionals in the decision-making process (Bartelink et al., 2018). De Haan and colleagues (2019) explored this area by assessing child protection workers and post-graduate students' judgements on Parenting Capacity Assessments (PCAs). A number of professionals (child welfare board professionals, children's court judges, and masters' students) were used in the study to find what factors influenced their decision-making during the out-of-home placement process (de Haan et al., 2019). The findings showed that attitudes towards parents' ability to change, and attitudes towards harmfulness were the factors that had the most impact their decisions to place children in out-of-home care (de Haan et al., 2019).

Van der Asdonk et al. (2020) stated that there are several additional limitations of PCAs in practice that have been reported. For example, they often only occur at one time point, do not include interactions in the home environment, and emphasise parents' weaknesses more than their strengths. Van der Asdonk and colleagues (2020) have suggested that in order to reduce the impact of these limitations, a more structured evidence-based approach should be encouraged. Eve and colleagues (2014) surveyed professionals (social workers, psychologists, lawyers, and magistrates) to find the factors that influence their decision-making during PCAs. Their study demonstrated six main themes: insight, willingness and ability, day-to-day versus complex/long-term needs, ability to put the child's needs before their own, fostering attachment, and consistency versus flexibility. The large volume of children involved with child protection, whose parents have been diagnosed with BPD, or fit the DSM criteria, could be explained by the difficulty society has separating people diagnosed with BPD from their illness. Additionally, as there is no current evidence-based, systematic approach to these decisions, the likelihood of stigma being involved in the decision process is high.

As previous literature suggests, individuals diagnosed with BPD have difficulty engaging in treatment (potentially due to the stigma associated with the illness), in addition to the symptoms of the illness including fear of abandonment and hypervigilance to rejection. Fortunately, multiple psychological therapies have been developed and are found to be effective for the treatment of BPD, including dialectical behavioural therapy (DBT), psychodynamic therapy and schema-focussed therapy (SFT), to name a few (Australian Psychological Society, 2018; Linehan, 1993). If more child protection workers were encouraged to recommend more services to families diagnosed with BPD instead of placing their children in out-of-home care, the level of children in care could decrease. Children of parents diagnosed with BPD will continue to be placed "quicker" if there is no knowledge or understanding about the illness and its effects, and the viscous cycle of symptoms and stigma will continue. It has been noted that social workers and caseworkers tend to under-recognise BPD symptoms as they are not trained in identifying mental illnesses (Laporte et al., 2018). Unfortunately, psychiatrists, who are trained in identifying mental illnesses have also been found to under-recognise BPD, even when DSM criteria are met (Zimmerman et al., 2008). Improving knowledge in this area by providing training may help improve the current practices involved with PCAs and the out-of-home placement process.

The Present Study

Based on a review of previous research and identification of the aforementioned gaps in the literature, this study will examine attitudes towards people diagnosed with BPD, using a sample of current child protection workers, previous child protection workers and students studying psychology, social work and law. The study will examine whether people within these settings view the parenting capacity of parents diagnosed with BPD differently than parents diagnosed with post-natal depression (PND). PND will be used as a controlling factor, in comparison to BPD; the literature shows that mental illness in general, carries a

large amount of stigma, therefore it is important to differentiate the level of stigma associated with parents diagnosed with BPD and other mental illness diagnoses. Vignettes drawn from the child protection literature will be used to compare attitudes towards the parents parenting capacity (one vignette stated a diagnosis of BPD, and the other PND). The study will also examine students and professionals' attitudes, skills, optimism for treatment and empathy towards people diagnosed with BPD in general and explore whether there is a difference in attitudes depending on the level of experience (student vs qualified professional).

Based on the literature, we hypothesised that participants would assess parents with a diagnosis of BPD as having poorer parenting capacity when compared to parents with a diagnosis of PND. Based on the literature, it was also hypothesised that negative attitudes (attitudes, skills, empathy and treatment optimism) will be associated with poorer perceived parenting capacity towards the parent with a diagnosis of BPD. Due to the conflicting literature on whether students' attitudes are different to professionals' attitudes, we propose the following research question:

1. Is there a difference between professionals and students' attitudes towards parents diagnosed with BPD?

Method

Participants

The sample of participants consisted of 104 females, 16 males and 2 non-binary peoples (N = 122), ranging in age from 18-69 (M = 27.85, SD = 10.97) who previously or currently worked with families and/or children involved with child protection, as well as students who may work in this context through future employment. Professionals (past and current child protection workers) ranged in age from 18-69 and students ranged in age from 18-50. Of the sample, two participants were of Aboriginal or Torres Strait Islander heritage, and 12 participants spoke a language other than English at home. Participants were excluded

if they were not over the age of 18 and not fluent in English. Student participants that were not enrolled in a course relevant to child protection were also excluded from the study. A full list of descriptive statistics can be found in Table 1.

Table 1

Statistics for participants split by group

		Professionals *N* = 49		Students *N* =73	
		n / *M*	% / *SD*	*n* / *M*	% / *SD*
Age		34.98	11.54	23.07	7.47
Gender	Female	46	93.9	58	79.5
	Male	3	6.1	13	17.8
	Non-binary			2	2.7
Industry experience (years)					
	Recent grad (<5)	19	38.8		
	Early career (5-10)	14	28.6		
	Mid-career (10-20)	7	14.3		
	Late career (20+)	5	10.2		
Mental illness experience		48	98	6	8.2
BPD experience		44	89.8	10	13.7
Discipline studying					
	Law			23	31.5
	Psychology			39	53.4
	Social work			9	12.3
	Other			2	2.7

Note. Experience strictly refers to professional experience.

Ethics approval was obtained through Adelaide University School of Psychology Human Research Ethics Subcommittee (approval number APP 22/59) before recruitment began. Some (n = 31) of the student participants received a small amount of extra credit at the University of Adelaide, through the School of Psychology Research Participation System (SONA). Beyond this there was no incentive for participation. The study was advertised through social media posts and by mailing University Course Coordinators requesting they post on their online courses for students to see, using a flyer (see Appendix B). For the study to have 80% power with a medium effect size of d = .50 and a = .05, a G*Power analysis was conducted and showed that 115 participants were required. The final sample satisfied these requirements.

Measures

Vignettes.

Vignettes in the current study were adopted from the University of Alabama School of Social Work (n.d.). The vignettes were initially designed by The Alabama Higher Education Consortium on Child Welfare and used for the purpose of enhancing social work training and education, and child welfare practices in Alabama, making them most appropriate for this study due to a similar targeted audience. Each of the original case studies were developed by a representative of the university alongside a social worker with child welfare experience, then reviewed by a consultant with child welfare expertise. The case studies were adapted for their use in the current survey due to the length and quantity of information, and to include a parental diagnosis of mental illness testing whether a diagnostic label would impact participants judgements of parenting capacity. The main difference between each of the vignettes was the diagnosis of the parent. Some details were altered to reduce participant bias, as it was expected that repetition of exact details would make it

obvious that the diagnosis alone was all that was being assessed. Otherwise, the outcome and main components of the vignettes were constant across both cases (see Appendix A).

Assessment of Parenting Capacity

Each assessment conducted within child protection settings is case-by-case and based on child protection department policies, clinical knowledge and experience as well as information drawn from multiple sources. However, to the authors knowledge there are no standardised tools to assess how clinicians judge parenting capacity, therefore, it was necessary to adapt one based on previous research. To assess judgements about parenting capacity based on the vignettes, participants were asked to assess several statements utilising a Likert scale ranging from "*Extremely unlikely*" = 1 to "*Extremely likely*" = 5. Scoring was interpreted using the raw total score (maximum score = 35). Higher scores equated to higher perceived parenting capacity, and lower scores equated to poorer perceived parenting capacity. Statements were developed based on the literature regarding key factors professionals use when judging the capacity of the parents (Eve et al., 2014). "*Insight*" refers to the "awareness of one's role as a parent, including understanding your individual child, their needs, and your ability to provide for those needs" (Eve et al., 2014, p. 118). "*Willingness and ability*" refer to "a parent's motivation to parent coupled with a sufficient capability to parent long-term" (Eve et al., 2014, p. 118). "*Day-to-day versus complex/long-term needs*" was defined as "meeting the basic developmental needs of a child… whilst also balancing the longer term needs of a child, enabling the child to reach their potential and develop into a well-adjusted human being" (Eve et al., 2014, p. 119). "*Child's needs before own*" refers to "a parent's ability to identify their child as a dependent person, prioritising the child's needs, which my involve sacrifice and protection" (Eve et al., 2014, p. 119). "*Fostering attachment*" was defined as "the need for caregivers to encourage bonding and attachment with a child, in order to establish security, comfort, and confidence" (Eve et al.,

2014, p. 119-120). Finally, "*consistency versus flexibility*" refers to "the ability of a parent to provide consistent parenting in all regards, however at the same time remain flexible and open to change" (Eve et al., 2014, p. 120). Cronbach's alpha in the current study was high (α = .89), indicating good internal consistency.

Assessment of Attitudes

Multiple measures were combined to assess attitudes towards people with a diagnosis of BPD. In particular, given the aforementioned literature the authors are interested in understanding clinician's assessment of their own skill, knowledge, empathy and optimism towards treatment. In the absence of a measure that assessed all these factors, relevant subscales were pulled along with items from other assessments which have been used throughout the literature.

Treatment Optimism Scale (TO). The treatment optimism scale was adapted from the Black et al. (2011) attitudes toward borderline personality disorder scale. The subscale was originally comprised of 5-items rated on a 5-point Likert Scale ranging from "*strongly disagree*" = 1 to "*strongly agree*" = 5. Item 4 "The prognosis for the treatment of BPD is hopeless" was reverse scored. Given the current study explored attitudes towards the effectiveness of treatment, specifically psychotherapy, this item was split into long-term and short-term therapy effectiveness, and the medication item was removed. Total subscale score ranges between 5-25, with higher scores indicating greater treatment optimism for people with a diagnosis of BPD. However, it became apparent that in the current study Cronbach's alpha for the adapted subscale was below average (α = .49) when all 5 items were included. Removing Item 4 and Item 5 from the measure, Cronbach's alpha for the study was acceptable (α = .67), which showed an improvement resulting in sufficient reliability. Therefore, for the purposes of analysis, this study only included Items 1-3. As such the revised range of the total score was 3-15.

Empathy Scale (ES). The empathy subscale in the current study was drawn from the Borderline patients – Emotional Attitudes Inventory (Bodner et al., 2011). In the current study, the empathy subscale included 3 of the original 5 items, scored on a 5-point scale ranging from "*strongly disagree*" = 1 to "*strongly agree*" = 5. The total subscale score ranged between 3-15. Higher scores indicated greater empathy for people with a diagnosis of BPD. Internal consistency for the empathy subscale in previous research was moderate (α = .60; Bodner et al., 2011). For the adapted version in the current study, Cronbach's alpha was acceptable (α = .70), which shows sufficient reliability.

Attitudes and Skills Questionnaire (ASQ). The ASQ (Krawitz, 2004) is a six-item measure that aims to assess treatment providers attitudes towards working with people with BPD. Items included were related to willingness, enthusiasm, confidence, theoretical knowledge and clinical skills. The original scale included an item assessing optimism however this was excluded in this study due to the inclusion of the aforementioned treatment optimism scale. 3 items used in this study were scored on a 5-point scale ranging from "*strongly disagree"* = 1 to "*strongly agree*" = 5. The other 2 items used in this study were scored on a 5-point scale ranging from "*poor*" = 1 to "*excellent*" = 5. The mean score for each item is reported as well as a total score. Higher scores indicate more positive attitudes towards people with a diagnosis of BPD. In previous research, the internal consistency for the ASQ was high (α = .82; Day et al. 2018). Cronbach's alpha for this study was high (α = .73), which shows acceptable reliability.

Procedure

Participants were provided with information on procedures, benefits and risks, contact information of the researchers, and voluntary participation then gave their informed consent prior to completing the survey. As the survey was anonymous, no details of the participants were recorded, therefore the results and how to acquire them was not explained. Eligible

participants completed the anonymous survey online via Qualtrics (see Appendix A). A link to the survey was provided through the SONA system, provided to university course coordinators, and posted on social media sites. The participants were informed, prior to survey completion, that the survey was examining attitudes towards parents with a diagnosis of mental illness and would require 15 minutes of their time. No information related directly to BPD was shared with participants to limit response bias. The information sheet also included contact numbers of the researchers in the case of distress or questions relating to the study.

The survey started with a series of demographic questions, then followed to the first vignette (i.e., where the parent had a diagnosis of PND). Participants were then requested to answer questions relating to the capacity of the parent, based on the vignette. Participants were then asked to read a second vignette (i.e., where the parent had a diagnosis of BPD), followed by the same questions relating to the parenting capacity. After rating the vignettes, all participants were asked to rate their attitudes towards people with a diagnosis of BPD (i.e., assessment of attitudes).

Analysis

The survey was started by 202 participants. Of these, 82 (40.6%) participants were excluded for not meeting study criteria, failing to complete the survey or failing to provide consent, resulting in a final sample of 122 participants. Data cleaning began by removing outliers and missing data. Data were screened for accuracy and statistical assumptions were tested. Assessment of parenting capacity difference in scores were not normally distributed, as assessed by Shapiro-Wilk's test ($p < .001$). Therefore, a Wilcoxon signed-rank test was conducted as the non-parametric test analysing the first and second hypothesis. The third research question was analysed using Bivariate Pearson Correlations; all assumptions were met including normality and linearity, and outliers ($n = 6$) were removed prior to running the

analysis. The final hypothesis was tested using Welch's t-test, due to there being unequal variances. The assumption of normality was met. Past workers and current workers were combined to create the 'professionals' variable, then analysed in comparison to the students.

Results

First Hypothesis

A Wilcoxon signed-ranks test indicated that parents diagnosed with PND scored statistically significantly higher on the assessment of parenting capacity (M = 21.89) than parents with BPD (M = 20.91), Z = 2.62, $p < .05$, indicating that parents diagnosed with BPD were assessed as having poorer parenting capacity compared to parents with a diagnosis of PND. A full list of comparisons across all assessment ratings can be found in Table 2, which is split by professionals and students.

Table 2

Attitudes towards people with a diagnosis of BPD and parenting capacity assessment ratings split by professionals' vs students

		Professionals *N* = 49 *M (SD)*	Students *N* =73 *M (SD)*	*p (sig.)*	*F*
ASQ	Total	18.52 (3.35)	16.54 (3.52)	.003*	9.51
	Willingness	4.53 (0.71)	4.64 (0.67)	.380	0.78
	Enthusiasm	3.53 (1.04)	3.99 (0.96)	.017*	5.94
	Confidence	3.92 (0.93)	3.19 (1.14)	.000**	14.88
	Knowledge	3.43 (0.82)	2.86 (1.08)	.001*	10.77
	Skills	3.06 (0.99)	1.77 (1.01)	.000**	49.54
ES Total		12.12 (1.94)	12.79 (1.75)	.059	3.67
TO Total		11.26 (1.72)	9.78 (2.50)	.000**	15.14
PCA PND					
	Total	23.02 (5.72)	21.14 (5.35)	.070	3.34
	Willingness	3.41 (1.24)	2.95 (1.12)	.038*	4.42
	Day-to-day	3.33 (1.01)	2.90 (1.08)	.030*	4.85
	Long-term	3.33 (1.14)	2.79 (1.10)	.012*	6.53
	Attachment	3.20 (1.04)	2.81 (1.10)	.047*	4.05
	Consistent	2.82 (0.97)	2.49 (0.96)	.073	3.28
	Child first	3.33 (1.01)	3.47 (1.05)	.465	0.54
	Limitations	3.61 (1.02)	3.73 (1.20)	.575	0.32
PCA BPD					
	Total	21.86 (6.45)	20.27 (5.26)	.157	2.04
	Willingness	3.18 (1.22)	2.93 (1.04)	.239	1.40
	Day-to-day	3.00 (1.22)	2.82 (1.04)	.406	0.69
	Long-term	3.12 (1.09)	2.74 (1.00)	.053	3.85
	Attachment	3.12 (1.07)	2.97 (0.99)	.437	0.61
	Consistent	2.94 (1.03)	2.42 (0.93)	.006*	7.92
	Child first	3.24 (0.95)	3.11 (1.01)	.453	0.57
	Limitations	3.24 (1.05)	3.27 (1.15)	.885	0.02

Note. PCA = Assessment of Parenting Capacity scores. *$p < .05$ **$p < .001$.

Second Hypothesis

Pearson correlation coefficients (one-tailed) were computed to assess the linear relationship between judgements of parenting capacity towards parents with a diagnosis of BPD and participants attitudes/skills relating to BPD. There was a very weak positive correlation between the two variables, $r(120) = .13$, $p = .082$; however, this was not statistically significant. A Pearson correlation coefficient was computed to assess the linear relationship between judgements of parenting capacity in the parent with a diagnosis of BPD scenario and participants empathy towards patients with BPD. There was no statistically significant correlation found between the two variables, $r(120) = -.03$, $p = .383$. A Pearson correlation coefficient was computed to assess the linear relationship between parenting capacity judgement on BPD parents and participants treatment optimism for BPD. There was a statistically significant correlation between the two variables, $r(120) = .17$, $p < .05$. A full Pearson correlation matrix can be found in Table 3.

Table 3

Correlation Matrix

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1. PCA BPD	1.00															
2. Willingness	.752**	1.00														
3. Meets day-to-day needs	.852**	.715**	1.00													
4. Meets long-term needs	.831**	.537**	.672**	1.00												
5. Fosters attachment	.803**	.484**	.676**	.666*	1.00											
6. Balances consistency vs flexibility	.806**	.529**	.631**	.703**	.605**	1.00										
7. Child's needs first	.776**	.453**	.557**	.562**	.556**	.560**	1.00									
8. Acknowledges limitations	.673**	.374**	.404**	.437**	.440**	.426**	.608**	1.00								
9. ASQ Total	.130	.110	.021	.152	.122	.118	.017	.156*	1.00							
10. Willingness	.003	.028	-.013	.055	.066	-.049	-.049	-.023	.498**	1.00						
11. Enthusiasm	.109	.006	.061	.042	.126	.050	.132	.186*	.619**	.476**	1.00					
12. Confidence	.080	.080	-.025	.143	.073	.117	-.065	.111	.848**	.277**	.354**	1.00				
13. Knowledge	.141	.084	.045	.148	.156*	.138	.051	.155*	.793**	.158*	.280**	.579**	1.00			
14. Skills	.089	.174*	.011	.118	.006	.119	-.005	.062	.742**	-.020	.095	.615**	.595**	1.00		
15. Treatment Optimism	.166*	.122	.057	.209*	.096	.160*	0.96	.174*	.775**	.199*	.349**	.700**	.654**	.655**	1.00	
16. Empathy	-.027	-.133	-.122	-.044	.052	-.098	.062	.139	.225*	.215*	.333**	.184*	.138	-.020	.156*	1.00

Note. PCA = Assessment of Parenting Capacity scores. *$p < .05$ **$p < .001$.

Research Question

The mean for the professionals' group for the parenting capacity for BPD was 21.86 (n = 49, SD = 6.45), whereas the students' group was 20.27 (n = 73, SD = 5.26). A Welch two-samples t-test showed that the difference was not statistically significant, $t(88.7) = 2.04$, $p = .157$. A Wilcoxon signed-ranks test indicated that professionals scored the parent diagnosed with PND higher in their capacity to be 'willing to parent at all times' (M = 3.41) than the parent with BPD (M = 3.18), $Z = 1.72$, $p = .085$, however this is not a statistically significant difference. A Wilcoxon signed-ranks test indicated that students also scored the parent diagnosed with PND higher on this item (M = 2.95) than parents with BPD (M = 2.93), $Z = 0.17$, $p = .866$, however this was not a statistically significant difference.

A Wilcoxon signed-ranks test indicated that professionals scored the parent diagnosed with PND higher on their capacity to address the basic day-to-day needs of the child (M = 3.33) than the parent with BPD (M = 3.00), $Z = 1.87$, $p = .062$, however this is not a statistically significant difference. A Wilcoxon signed-ranks test indicated that students also scored the parent diagnosed with PND higher on this item (M = 2.90) than the parent with BPD (M = 2.82), $Z = 0.64$, $p = .523$, however this is not a statistically significant difference.

A Wilcoxon signed-ranks test indicated that professionals scored the parent diagnosed with PND higher in their capacity to meet the long term needs of the child (M = 3.33) than the parent with BPD (M = 3.12), $Z = 1.62$, $p = .105$, however this is not a statistically significant difference. A Wilcoxon signed-ranks test indicated that students also scored the parent diagnosed with PND higher on this item (M = 2.79) than the parent with BPD (M = 2.74), $Z = 0.53$, $p = .597$, however this is not a statistically significant difference.

A Wilcoxon signed-ranks test indicated that professionals scored the parent diagnosed with PND higher on their ability to develop attachment with their child (M = 3.20) than the parent with BPD (M = 3.12), $Z = 0.50$, $p = .615$, however this is not a statistically significant

difference. A Wilcoxon signed-ranks test indicated that students scored parents diagnosed with PND lower on their ability to develop attachment with their child (M = 2.81) than the parent with BPD (M = 2.97), Z = 1.61, p = .107, however this is not a statistically significant difference.

A Wilcoxon signed-ranks test indicated that professionals scored the parent diagnosed with PND lower on their ability to balance consistent parenting approaches (consistency versus flexibility; M = 2.82) than the parent with BPD (M = 2.94), Z = 1.28, p = .201, however this was not a statistically significant difference. A Wilcoxon signed-ranks test indicated that students also scored the parent diagnosed with PND lower on this item (M = 2.49) than the parent with BPD (M = 2.42), Z = 0.53, p = .597, however this is not a statistically significant difference.

A Wilcoxon signed-ranks test indicated that professionals scored the parent diagnosed with PND higher in their ability to put their child's needs before their own (M = 3.33) than the parent with BPD (M = 3.24), Z = 0.52, p = .600, however this was not a statistically significant difference. A Wilcoxon signed-ranks test indicated that students scored the parent diagnosed with PND significantly higher in their ability to put their child's needs before their own (M = 3.47) than the parent with BPD (M = 3.11), Z = 2.66, $p < .05$.

A Wilcoxon signed-ranks test indicated that professionals scored the parent diagnosed with PND significantly higher on their ability to acknowledge their own parenting limitations (M = 3.61) than the parent with BPD (M = 3.24), Z = 2.27, $p < .05$. A Wilcoxon signed-ranks test indicated that students also scored the parent diagnosed with PND significantly higher on this item (M = 3.73) than the parent with BPD (M = 3.27), Z = 3.06, $p < .05$. A full comparison of the groups can be found in Table 2.

An additional Pearson correlational analysis was conducted to assess whether there was a relationship between participants professional experience with BPD and their perceived

parenting capacity of the parent with BPD. A comparison was also done between professionals and students. There was a very weak positive correlation between the two variables for the professionals, $r(49) = .18$, $p = .206$; however, this was not statistically significant. However, there was no statistically significant correlation found between the two variables for the students, $r(73) = -.04$, $p = .717$.

Discussion

The current study aimed to examine whether child protection workers viewed parents diagnosed with BPD differently to parents diagnosed with PND. The study also aimed to examine whether there was a difference between professionals and students, and whether experience or attitudes influenced these views. Overall, perceptions were found to be more negatively associated with parents that had a diagnosis of BPD. The Wilcoxon signed rank test showed that perceived parenting capacity was significantly lower for these parents than parents diagnosed with PND, meaning the first hypothesis was supported. There is a substantial amount of research documenting that stigma is heavily associated with BPD (Aviram et al., 2006; Klein et al., 2021). The current study is a representative example of this stigma. In fact, analyses have shown that participants judged parents diagnosed with BPD significantly harsher on their parenting capacity. Interestingly, the gap between BPD and PND diagnoses for parenting capacity is much larger for professionals than for students, suggesting greater bias by professionals. In addition, students judged parenting capacity of both PND and BPD lower than professionals. This is consistent with the findings from previous studies, indicating that students reportedly implement harsher decisions when limited information is provided (Davidson-Arad et al., 2003; De Ruiter et al., 2013).

Interestingly, students' ratings of the parent's capacity to foster attachment was associated with lower scores for the PND diagnosis. However, students rated the parent

diagnosed with BPD slightly lower on all other items of the parenting capacity assessment. Professionals, on the other hand, rated the parent diagnosed with BPD slightly lower on all items of the parenting capacity assessment, aside from the consistency item. Professionals rated the parent diagnosed with PND more able to balance consistency compared to the parent diagnosed with BPD. This shows that professionals and students differ in their attitudes towards parents with a diagnosis of BPD, when compared to parents with a diagnosis of PND. In addition, the consistency item was the only item of the parenting capacity assessment for BPD that had a significant difference in ratings between professionals and students. However, the parenting capacity assessment for PND contained numerous items with significant difference between professionals and students' ratings. It is recommended that future research is conducted in order to explore these findings further.

The data, however, did not entirely support the second hypothesis. Treatment optimism was the only statistically significant relationship with participants judgements on the BPD parenting capacity assessment. The current study lends further support to previous research, as the findings show that more treatment optimism is associated with higher perceived parenting capacity, for parents with BPD. To date, there is a growing body of literature documenting the effectiveness of psychoeducation for numerous disorders including BPD. Multiple studies have determined lack of treatment optimism as the contributing factor for stigma associated with BPD. Specifically, Aviram and colleagues (2006) and Kelly and May's (1982) studies concluding that treatment optimism is of the upmost importance in reducing stigma associated with BPD. Interestingly, treatment optimism was also significantly correlated with the parent's ability to meet the long-term needs of the child, balance consistency and acknowledge limitations. This indicates that believing in parents' ability to change, as stated by de Haan and colleagues (2019), has an impact on the decision-making process.

Some components to the assessment of attitudes measure were found to be positively correlated with parenting capacity judgements for the BPD parent. This finding lends further support for Ring and Lawn's (2019) conclusion that stigma relating to BPD can be reduced through improving knowledge of the disorder. Additionally, perception of the parents' ability to acknowledge their own limitations was significantly associated with enthusiasm to work with people with a diagnosis of BPD. This indicates that professionals may be more willing to work with people with a diagnosis of BPD if they believe the person is able to acknowledge their own limitations. This can hopefully be extended for use within the healthcare system, to improve lack of enthusiasm indicated in the literature (Black et al., 2011; Markham, 2003). Interestingly, empathy was negatively associated with higher ratings on the parenting capacity assessment, indicating that having higher levels of empathy, does not relate to higher scores on perceived parenting capacity. This is contradictory to Ring and Lawn's (2019) finding that higher levels of empathy can help reduce stigma. Importantly, there were significant positive correlations between each of the items of the parenting capacity assessment, indicating the measure adapted for this study is an appropriate tool that may be utilised in future studies. The ASQ had a number of positive significant relationships, particularly with treatment optimism and empathy, indicating the assessment of attitudes measure assessed a wide range of attitudes regarding BPD specifically, and these related to each other significantly.

The research question aimed to determine whether there was a difference between students and professionals in their parenting capacity scores. As mentioned, the results show a greater bias by professionals when comparing judgements of parenting capacity between parents with a diagnosis of BPD and parents with a diagnosis of PND. In addition, the gap between professionals and students was greater for PND parenting capacity scores than it was for the BPD parenting capacity scores. This indicates that students may be more likely to

judge closer to the middle through lack of understanding, however those with more experience in the field, may potentially be more likely to judge based on experience. To analyse this, a correlational analysis was conducted. The results showed that while there was a slight difference between professionals and students, the relationship was not significant in either group. This finding is contradictory to Black and colleagues (2011) study showing experience having a large impact on attitudes towards people diagnosed with BPD. A reason for the current study having opposing results could be due to the small sample size, and unequal groups. Therefore, it is recommended that more research be done into this relationship.

Further analyses were conducted to examine the difference between professionals' and students' assessment of attitudes scores, resulting in a statistical significance, consistent with previous findings (Britner & Mossler, 2002; Davidson-Arad et al., 2003; De Ruiter et al., 2013). Professionals scored significantly higher on the total score for ASQ. Professionals rated their confidence in working with people with a diagnosis of BPD, their theoretical knowledge of BPD and their clinical skills in working with people with a diagnosis of BPD, significantly higher than students. Surprisingly though, students rated their willingness to work with people with a diagnosis of BPD higher and their enthusiasm in working with people with a diagnosis of BPD significantly higher than professionals. There was no significant difference in empathy scores, however contradictory to previous research, professionals scored significantly higher in treatment optimism than students.

The research question also explored the differences between professionals and students in their scores on each item of the parenting capacity assessment, giving a more in-depth analysis. Majority of the items were slightly higher for the parent with PND than the parent with BPD, in both groups. However, acknowledging limitations was the only item where PND was significantly higher than BPD, for both groups. This indicates that both

groups believe BPD parents are unable to acknowledge their own limitations. The child's needs first item was significantly higher for the students' group, but not the professionals group. Indicating that students believe parents diagnosed with BPD are much worse at putting their child first, than parents diagnosed with PND. The only item that both groups rated the parent diagnosed with BPD slightly higher than the parent with PND, was the consistency item, however this difference was not found to be significant. This means that both groups believed that those diagnosed with BPD are better equipped at balancing consistent parenting approaches, than parents diagnosed with PND. Interestingly, there was only one other opposing result. Professionals rated the parent's ability to foster attachment slightly higher for the PND diagnosis than the BPD diagnosis. Whereas students scored the BPD parent slightly higher than the parent diagnosed with PND. Although these were not significant findings, it indicates that students and professionals have differing beliefs on which aspects of parenting are more parents diagnosed with BPD struggle with more.

While there were interesting findings, there were a few limitations to the study. The treatment optimism measure had to be reduced to only three items due to the below average reliability score for the full measure. The measure did not contain two major components ('The prognosis for the treatment of BPD is hopeless' and 'Brief interventions are effective in helping people with borderline symptoms/diagnosis'). As the findings were consistent with previous studies, the overall effect was likely limited. Taking this into consideration, the items being adapted could help explain the treatment optimism scale having low reliability. The original scale was found to have good reliability (Black et al., 2011), although removing the medication item and splitting the therapy item into long-term and short-term, caused the reliability to reduce. It is difficult to say whether this influenced the overall results of the study.

Another methodological limitation of the current study was the lack of appropriate measures available. Firstly, as the vignettes were adapted from online resources, it is difficult to assess the adequacy and appropriateness of the vignettes for testing the hypotheses. In order to limit participant bias, keeping details similar between the vignettes was important. However, it cannot be determined with total accuracy, that the sole reason BPD scored lower than PND was due to the diagnosis. Other factors that could determine the outcome include, participants judging neighbour differently to café owner or having a preconceived idea that kids being at the playground alone at night is worse than being at home alone. The parent in the BPD vignette, arrives home an hour later than the parent in the PND vignette, therefore the participant might view this as 'worse' parenting, or that dirty dishes are worse than dirty clothes. Secondly, the assessment of parenting capacity was created by the author through findings from previous research. While this is a major strength of the research, there is limited evidence supporting its use as a tool to assess capacity of parenting.

It is difficult to understand entirely what the participants' thought processes were during their judgements on the capability of each parent, and unfortunately, there are a few differences that could impact their decisions. It is recommended that future research efforts control for these differences. It would be beneficial to add a comment box after each parenting capacity assessment, asking the participants to further explain their decision process. Further exploration of whether there is stigma towards parents diagnosed with BPD in child protection settings its influence on the decision-making process is necessary. It is worth noting that the vignettes included a short scenario providing limited detail to participants, whereas real-life assessments would involve a collation of more in-depth information, multiple assessments, face-to-face meetings, etc. therefore limiting the study's methods. However, in spite of this, participants still rated the parent with a diagnosis of BPD lower, regardless of the fact that they were given no information relating to the disorder and

were admittedly not confident in their knowledge or skills, which is concerning. This finding further demonstrates that stigma is involved in the decision-making process, even when limited information is provided. It would be beneficial however, to examine whether providing participants with more information impacts their judgements. Interestingly, the previous literature on hasty decision-making is contradictory. Multiple studies found that students were more likely to make decisions based off limited information (Davidson-Arad et al., 2003; De Ruiter et al., 2013), whereas Bartelink and colleagues (2018) found that there were no differences between experienced professionals and students. The current study falls somewhere in between; there certainly is a difference between groups, however both professionals and students were able to make decisions based off little information.

Potential projects could extend to providing participants with a series of questions relating to what interventions or assessments might be implemented after this. It would be beneficial for future researchers to explore whether these children would be placed in out-of-home care or not. Particularly due to previous findings suggesting that child protection workers place children in out-of-home care more often and more quickly if the parent has BPD (Laporte et al., 2017). Future research could use an education program on BPD as an intervention to examine the impact of psychoeducation. This is important in understanding whether knowledge of the disorder equates to better perceptions of individuals with a diagnosis of BPD. Students scored below 2 and professionals scored a mean of 3 in clinician skills relating to BPD. Majority of the professionals stated that they had previously worked with people with a diagnosis of BPD, therefore this number should be higher. The low scores show that further training needs to be introduced within child protection settings to help reduce stigma. There is evidence of this working within health settings (Knaak et al., 2015), and in child protection settings (Desrosiers, 2021). Knaak and colleagues implemented a

training program and found that attitudes and behavioural intentions of health professionals and clinicians towards people diagnosed with BPD improved.

Desrosiers (2021) suggested that workers in these settings are trained on diagnostic criteria, prevalence, and etiological factors however there is a lack of information given regarding self-management skills and attitudes. In order to improve skills on how to work with parents diagnosed with BPD in practice, it is important to provide training in this area, given relational challenges. Desrosiers (2021) has explored this within child protection settings and developed two training programs specifically designed for workers within these settings. The first, TANGO, is a 22-hour training program which teaches workers to use DBT skills to regulate themselves, limit their own attitudes and emotional responses during difficult interventions with patients diagnosed with BPD. The second, My Child & Me (MC&M), is also based on DBT but proposes alternative strategies for dealing with parents diagnosed with BPD and is only a 9-hour program. Research is currently being conducted evaluating these two programs, however pre- and post- self-report measures have suggested that post-training clinicians reported improvement on emotional awareness, perceptions and attitudes and working with people with BPD was perceived as easier (Desrosiers, 2021).

Another recommendation would be to replicate the study by extending to other disciplines. For example, extending it to psychiatrists, nurses, and other health professionals as conducted in previous studies. This would increase the sample size and thereby add further support to the findings. It would be beneficial for future studies to include other parental diagnoses to further examine the impact of stigma on BPD when compared to multiple diagnoses. The current study can only conclude that BPD is associated with significantly greater stigma than PND.

In view of the limitations, the results of this study add to the body of evidence suggesting that BPD is heavily connotated with stigma. Although the findings lend some

support to the research indicating the benefits of psychoeducation, it is recommended that further education be implemented in child protective services (including but not restricted to BPD). Multiple studies have shown that stigma is heavily perpetuated through a lack of understanding. Corrigan et al. (2014) stated that overall, in order to reduce its negative impact on care seeking and treatment engagement, it is important to understand stigma. In addition, Ahmed and colleagues (2021) stated that providing psychoeducation is necessary as it allows people to better understand the group being stigmatised, allowing them to diminish any preconceived ideas that society might have unequivocally transferred. Ring and Lawn (2019) stated that stigma relating to BPD is heavily associated with poor health literacy and suggested that targeted education, advocacy & leadership will help eradicate this. Therefore, the efficacy of psychoeducation in the reduction of stigma is well-established. However, more research is needed to draw a conclusion on stigma relating to BPD with child protection workers. Particularly due to the oversaturation of parents involved with child protective services with a diagnosis of BPD. Although some of the findings were contradictory to previous research, it is important to acknowledge the adaption of the parenting capacity measure and take note of its strong reliability and strong correlations between each item. The adapted measure has the potential to be utilised in future research, which is a step in the right direction due to the lack of standardised measures for use within the child protection sector.

In sum, the current study has found that stigma is heavily associated with BPD within child protection settings. While findings show that attitudes, experience, and empathy have little impact on the perception of parents' ability, treatment optimism plays a significant role in stigma associated with BPD. More research is recommended to examine the impact of these judgements on the out-of-home decision-making process. Interestingly, the results suggest that students' judgements have significant differences of opinion to professionals. Due to professionals scoring concerningly low on clinical skills relating to BPD,

psychoeducation is recommended to help educate professionals on treatment and thereby reduce stigma.

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Appendix A

Qualtrics Survey

Attitudes towards parents with a mental illness diagnosis

Info Sheet **Participant Information Sheet**
PROJECT TITLE: Attitudes towards parents with a mental illness diagnosis
HUMAN RESEARCH SUBCOMMITTEE IN THE SCHOOL OF PSYCHOLOGY APPROVAL NUMBER: APP 22/59
PRINCIPAL INVESTIGATOR:
STUDENT RESEARCHER:
STUDENT'S DEGREE: Honours of Psychology

Dear Participant,
You are invited to participate in the research project described below.
What is the project about?
This research project is about exploring stigma associated with mental illness, particularly in child protection settings. The project will also look at whether there is less stigma associated around mental illness in parenting if a person has more knowledge of mental illness. The current research is lacking, so hopefully this project will work on filling the gap.
Who is undertaking the project?
This project is being conducted by *. This research will form the basis for the degree of Honours of Psychology at the University of Adelaide under the supervision of *and *. * and * also work at Borderline Personality Disorder Collaborative.
Why am I being invited to participate?
You are being invited as you are aged 18+, reside in Australia, and are fluent in English. You are also either a student of Psychology, Social Work or Law at University; or currently work or have previously worked with families in a child protection setting.
What am I being invited to do?
You are being invited to take part in a short online survey containing two short case studies followed by a series of questions relating to the case study. The survey will be anonymous therefore no follow-up or recording will be required.
How much time will my involvement in the project take?
The online survey should take approximately 15 minutes to complete. No follow-up sessions will be required.
Are there any risks associated with participating in this project?
There are no foreseeable risks associated with the survey, however you may experience some inconvenience through the time taken to complete the survey. If there is any discomfort or emotional distress due to the content of the survey, at any time during or after the survey, do not hesitate to use the contact numbers provided at the bottom of the participant information sheet.
What are the potential benefits of the research project?
The research may result in further understanding of mental illness within child protection settings.
Can I withdraw from the project?
Participation in this project is completely voluntary. If you agree to participate, you can withdraw from the study at any time. If you choose to withdraw, you will need to do so prior to submission of the survey as all data will be anonymous therefore will be unidentifiable.
What will happen to my information?
Participation in the survey is entirely anonymous therefore no information is identifiable. There are no limitations to de-identification as a large sample size is anticipated and anonymous consent will also be obtained prior to taking part in the survey.
Information and project records will be securely stored in a locked file on a hard drive, only the supervisor will have access to the data following completion of analysis. As per the Australian Code for the Responsible Conduct of Research, data will be retained by the university for five years from the date of publication. Raw data will not be shared to any person's outside of the research team.
The project will form an Honours thesis and may be submitted for review and publication at a peer-reviewed journal. Participants will not be identified as data from the anonymous surveys will be reported as a combined dataset in aggregate form.
A summary of results will not be shared as participant information will not be shared therefore participants will not be contactable.
Your information will only be used as described in this participant information sheet and it will only be disclosed according to the consent provided, except as required by law.
Who do I contact if I have questions about the project?
* Ph: 8313 ****; or
* Ph: 7425 ****; or
* Email: a1736093@student.adelaide.edu.au
What if I have a complaint or any concerns?
The study has been approved by the Human Research Subcommittee in the School of Psychology at the University of Adelaide (approval number APP 22/59). This research project will be conducted according to the NHMRC National Statement on Ethical Conduct in Human Research 2007 (Updated 2018). If you have questions or problems associated with

the practical aspects of your participation in the project or wish to raise a concern or complaint about the project, then you should consult the Principal Investigator. If you wish to speak with an independent person regarding concerns or a complaint, the University's policy on research involving human participants, or your rights as a participant, please contact the Human Research Ethics Subcommittee's Chairman for the School of Psychology on:
Phone: +61 8 8313 4936
Email: paul.delfabbro@adelaide.edu.au
Post: School of Psychology, Level 7, Hughes Building, North Terrace Campus, THE UNIVERSITY OF ADELAIDE, SA 5005
Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.
If I want to participate, what do I do?
Follow the prompts and hit submit once you have completed it.

Yours sincerely,
*

Consent
By continuing with this survey, I acknowledge that I have read the information sheet and consent to my information being shared. I understand that my consent is required to participate in the survey.

- I consent (1)
- I do not consent (0)

Skip To: End of Survey 1 If 'By continuing with this survey, I acknowledge that I have read the information sheet and consent...' = I do not consent

Display This Question:

If 'By continuing with this survey, I acknowledge that I have read the information sheet and consent... = I do not consen'

End of Survey 1
Sorry! Unfortunately, you are no longer eligible to participate. Your consent is required to continue on to the survey. Thank you for your time and consideration. Please click next and it will take you to the end of the survey.

Skip To: End of Survey If ' Sorry! Unfortunately, you are no longer eligible to participate. Your consent is required to conti...' Is Displayed

Part 1 Part 1 – Demographics
Q1. What is your age? (In years)

_____

Q2. What is your gender?

- Male (1)
- Female (2)
- Non-binary (3)
- Prefer not to say (0)

Q3. What is the language most spoken at home?

- English (1)
- Other - Please Specify (2) _____

Q4. What is your country of birth?

_____

Q5. Do you have Aboriginal or Torres Strait Islander heritage?

- Yes (1)
- No (0)

Q6. Are you:

- Currently working with families who have had contact with child protective services (1)
- Previously worked with families who have had contact with child protective services (2)
- Studying in a discipline where you may work with families who have contact with child protective services in the future (3)
- None of the above (0)

Skip To: End of Survey 2 If Q6. Are you: = None of the above

Display This Question:

If Q6. Are you: = None of the above

End of Survey 2
Sorry! You are no longer eligible to participate. It is a requirement that all participants currently work, have previously worked in child protection settings or study in a relevant discipline. Thank you for taking your time and consideration to participate in the survey. Please click next, this will take you to the end of the survey.

Skip To: End of Survey If 'Sorry! You are no longer eligible to participate. It is a requirement that all participants curre... ' Is Displayed

Display This Question:

If Q6. Are you: = Currently working with families who have had contact with child protective services

Or Q6. Are you: = Previously worked with families who have had contact with child protective services

Q6a. What was/is the role you have predominantly worked in when working with these families?

_____

Display This Question:

If Q6. Are you: = Previously worked with families who have had contact with child protective services

Q6b. How many years has it been since you worked in these settings?

_____

Display This Question:

If Q6. Are you: = Studying in a discipline where you may work with families who have contact with child protective services in the future

Q6a. If you are currently studying, what discipline?

- Law (1)
- Psychology (2)
- Social Work (3)
- Other - Please Specify (4) _____

Display This Question:

If Q6a. If you are currently studying, what discipline? = Psychology

Q6b. Do you wish to receive course credit through the University of Adelaide Undergraduate Research Participation System (SONA)?

- Yes (1)
- No (2)

Display This Question:

If Q6b. Do you wish to receive course credit through the University of Adelaide Undergraduate Resear... = Yes

Q6c. Please provide your University of Adelaide Student number below.

_____

Display This Question:

If Q6b. Do you wish to receive course credit through the University of Adelaide Undergraduate Resear... = Yes

Q6d. Please provide your unique student SONA code below.

_____

Q7. How many years of experience do you have, working in these contexts?

- Currently enrolled in a relevant course (0 years) (1)
- Recent graduate (less than 5 years) (2)
- Early career (5-10) (3)
- Mid-career (10-20) (4)
- Late career (20+) (5)

Q8. How many families have you worked with, where a parent has a mental illness?

- None (0)
- 1-5 (1)
- 6-10 (2)
- 11-20 (3)
- 21+ (4)

Q9. If you're not currently working with parents who are diagnosed with a mental illness, how many years has it been since you have?

- Please specify (1) _____
- N/A (2)

Part 2: In this section you will be asked to read a scenario and then answer several questions regarding. There are two scenarios to read and respond to. Please pay close attention to the scenarios and answer truthfully based on your opinions.

Vignette One
A café-owner contacted the Department of Child Protection (DCP) at 6:00pm to report two children, Jo (11) and Sam (1.5) alone at the local playground. Jo was apparently responsible for watching Sam while their mother, Paula was at work. Sam had a bad fall in the park and Jo didn't know what to do, so they sought help from the café-owner nearby. The café-owner was unable to contact Paula after several hours of trying. Jo stated that their mother would be home around 10pm, and that she worked nightshift at the hospital. Paula arrived home at 10:30pm and apologised as she was not able to keep her phone on her at work. She responded appropriately to the children and stated that she was having financial difficulties and covering extra shifts at the hospital for additional income. There were no immediate safety issues, however upon observation there

were quite a large stack of dirty clothes in multiple rooms throughout the house. Upon investigation, DCP are made aware that Paula has a diagnosis of post-natal depression.

Q10. Please indicate how likely you think...

	Extremely unlikely (1)	Somewhat unlikely (2)	Neither likely nor unlikely (3)	Somewhat likely (4)	Extremely likely (5)
This parent would be 'willing to parent at all times' (1PCA_1)	○	○	○	○	○
This parent is able to address the basic day-to-day needs of the child (e.g., physical, emotional, cognitive, etc.) (1PCA_2)	○	○	○	○	○
This parent is able to meet the long-term needs of the child, enabling them to develop a well-adjusted person (e.g., teaching the child socialisation and values expected by society, etc.) (1PCA_3)	○	○	○	○	○
This parent is able to develop attachment with their child (by providing comforting, nurturing and sensitivity responding to the child) (1PCA_4)	○	○	○	○	○
This parent is able to balance consistent parenting approaches (consistency versus flexibility) (1PCA_5)	○	○	○	○	○
This parent is able to put their child's needs before their own (1PCA_6)	○	○	○	○	○
This parent acknowledges their own parenting limitations (1PCA_7)	○	○	○	○	○

Part 2: In this section you will be asked to read a scenario and then answer several questions regarding. This is the second scenario to read and respond to. Please pay close attention to the scenario and answer truthfully based on your opinions.

Vignette Two
A neighbour contacted DCP at 9:30pm to report two children, Tyler (10) and Jade (2) alone at home. Tyler was apparently responsible for watching Jade while his mother, Julie was at work. Jade became ill so Tyler, unsure what to do, walked next door to the neighbour for her help. The neighbour was unable to contact Julie after two hours of trying. Tyler reported that he 'thought' his mother would be home around 11pm, and that she was working nightshift at the hospital. Julie arrived home at 11:15pm and apologised as she was not able to keep her phone on her at work. She responded appropriately to the children and stated that she was having money problems and covering extra shifts at the hospital for additional income. There were

no immediate safety issues, however upon observation there were quite a large stack of dirty dishes in the sink. Upon investigation, DCP are made aware that Julie has a diagnosis of borderline personality disorder (BPD).

Q11. Please indicate how likely you think...

	Extremely unlikely (1)	Somewhat unlikely (2)	Neither likely nor unlikely (3)	Somewhat likely (4)	Extremely likely (5)
This parent would be 'willing to parent at all times' (2PCA_1)	○	○	○	○	○
This parent is able to address the basic day-to-day needs of the child (e.g., physical, emotional, cognitive, etc.) (2PCA_2)	○	○	○	○	○
This parent is able to meet the long-term needs of the child, enabling them to develop a well-adjusted person (e.g., teaching the child socialisation and values expected by society, etc.) (2PCA_3)	○	○	○	○	○
This parent is able to develop attachment with their child (by providing comfort, nurturing and sensitivity responding to the child) (2PCA_4)	○	○	○	○	○
This parent is able to balance consistent parenting approaches (consistency versus flexibility) (2PCA_5)	○	○	○	○	○
This parent is able to put their child's needs before their own (2PCA_6)	○	○	○	○	○
This parent acknowledges their own parenting limitations (2PCA_7)	○	○	○	○	○

Part 3 - Attitudes towards parents with a mental illness

Q12. I have worked with a person with a diagnosis of borderline personality disorder (BPD)

- ○ Yes (2)
- ○ No (1)
- ○ N/A (0)

Q13. I am...

	Strongly disagree (1)	Somewhat disagree (2)	Neither agree or disagree (3)	Somewhat agree (4)	Strongly agree (5)
Willing to work with people with a diagnosis of BPD (ASQ_1)	○	○	○	○	○
Enthusiastic about working with people with a diagnosis of BPD (ASQ_2)	○	○	○	○	○
Confident working with people with a diagnosis of BPD (ASQ_3)	○	○	○	○	○

Q14.

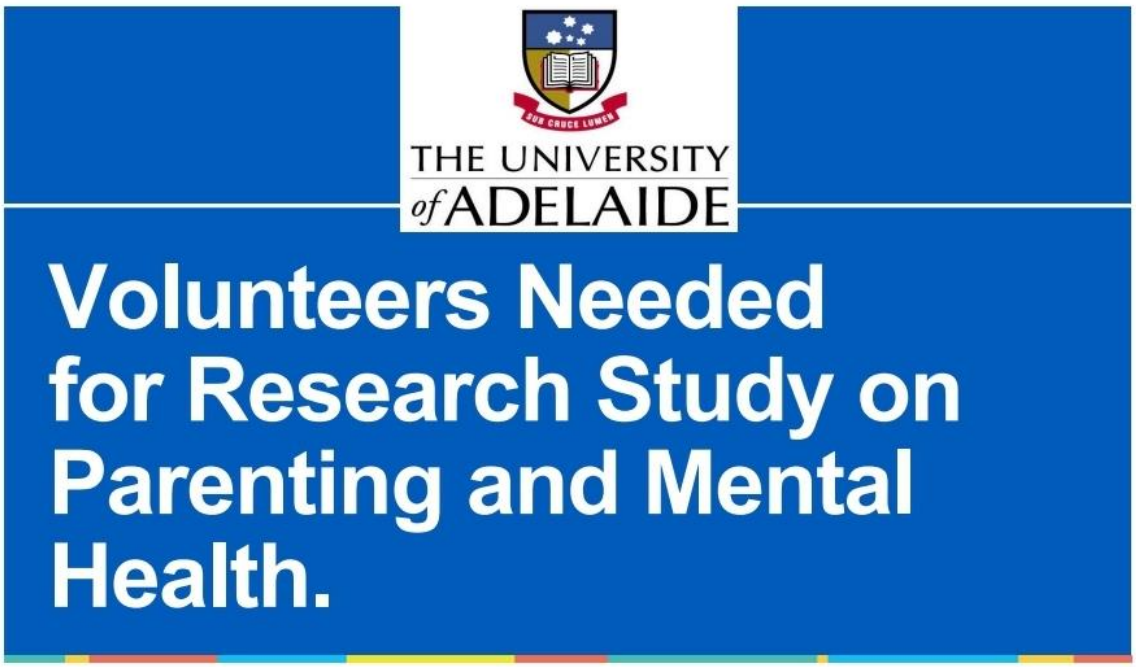
	Poor (1)	Fair (2)	Average (3)	Good (4)	Excellent (5)
My theoretical knowledge regarding BPD is... (ASQ_4)	○	○	○	○	○
My clinical skills in working with people with a diagnosis of BPD are... (ASQ_5)	○	○	○	○	○

Q15.

	Strongly disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Strongly agree (5)
I feel professionally competent in caring for a person experiencing borderline symptoms/diagnosis of BPD (TO_1)	○	○	○	○	○
I feel like I can make a positive difference in the lives of people experiencing borderline symptoms/diagnosis of BPD (TO_2)	○	○	○	○	○
Some long-term psychotherapies are effective in helping people with borderline symptoms/diagnosis of BPD (TO_3)	○	○	○	○	○
The prognosis for the treatment of BPD is hopeless (TO_4R)	○	○	○	○	○
Brief interventions are effective in helping people with borderline symptoms/diagnosis of BPD (TO_5)	○	○	○	○	○
I feel empathy towards people experiencing borderline symptoms/diagnosis of BPD (ES_1)	○	○	○	○	○
People with borderline symptoms/BPD evoke caring emotions in me (ES_2)	○	○	○	○	○
I would like to relieve the suffering of people with borderline symptoms/diagnosis of BPD (ES_3)	○	○	○	○	○

Appendix B

Flyer



You may be eligible for a short research study that could help improve our understanding of parenting and mental health.

You May Qualify If You

- Are over the age of 18
- Can speak fluent English
- Are a student of psychology, social work or law; OR
- Currently work in, or have previously worked with children and/or families who have had contact with child protection settings

Potential Benefits

Participating in this study may improve our overall understanding of parenting and mental health. This study aims to get an understanding of attitudes towards parents who are struggling with mental health within the system. Through doing this, more specific care and better communication can be provided to these families.

Participation Involves

- Completing a short survey containing case studies, followed by an assessment of knowledge and attitudes.
- The survey should take approximately 15 mins to complete.

FOR MORE INFORMATION

[redacted]

The online survey can be found

https://adelaideunisop.syd1.qualtrics.com/jfe/form/SV_eVgHW12DErXLN8q

University of Adelaide, School of Psychology. Flyer, Attachment 2 – v.1, 10/05/2022