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# Adult Attachment For African American Women Who Have Mothers With Borderline Personality Disorder

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This is to certify that the doctoral dissertation by

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Walden University
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Abstract

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MPhil, Walden University, 2019

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Dissertation Submitted in Partial Fulfillment

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## Abstract

The effects that borderline personality disorder (BPD) can have on the loved ones of those who suffer from the mental illness is significant and can be deleterious and enduring. Maternal BPD can adversely impact mother-daughter relationships by fostering abnormal connections and insecure attachment bonds. This is particularly the case for African American mothers, of whom research suggests that the early attachment bond between them and their daughters significantly shapes how their daughters behave, perceive themselves, and relate to others. The purpose of this qualitative transcendental phenomenological study was to explore how the experiences of being raised by a mother diagnosed with BPD affected subsequent adult attachments for African American women. Principles from Bowlby's attachment theory as well as Bartholomew and Horowitz's four-category model of adult attachment served as the conceptual framework for this study. Purposeful sampling and snowball sampling were used to recruit 11 African American women with mothers having BPD. Data were collected using semistructured interviews and analyzed using Colaizzi's method to determine emergent themes. Analysis of participants' responses revealed that although they were capable of pursuing healthy attachments and had the ability to form positive views of close relationships, they mainly presented adult attachment orientations indicative of dismissive-avoidant and anxious-preoccupied insecure attachment styles. In addition to contributing to family studies research and psychiatric literature, this study can provide information that can help African American women understand how their early mother-daughter attachment experiences may have influenced their current patterns of attachment. The study findings may also be useful to clinicians in fostering more secure interpersonal relationship patterns in their African American female clients.

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# Dedication

I dedicate this achievement to my beloved and dearly missed late father, Dr. Emmanuel Freeborn Onyeali. The resilient love and faith in the Lord Jesus Christ and the passion for education that you and Mom instilled in me has allowed me to reap this harvest of an accomplishment. I thank the Lord for blessing me with such a wonderful father. I will see you again one day in Paradise.

## Acknowledgments

All praise, honor, glory and thanksgiving belong to my God, through my Lord and my Savior, Jesus Christ. Without my relationship and resolve in Him, I would not have had the wisdom, fortitude, courage, or endurance needed to be the progenitor of such a study. Secondly, I acknowledge with deep gratitude my family, who include my dear, late father, Dr. Emmanuel Freeborn Onyeali (PhD); my valiant mother, Dr. Anastasia Nkechi Onyeali (PhD); my exceptional sister Dr. Mary Ann Ngozi Onyeali (MD); my destined brother, Joseph Chukwuemeka Onyeali (BA); and my invaluable sister Rosemary Ihouma Chineye Onyeali (MA). Without my family base, I would not have been enlightened to the unbridled and ambitious nature of knowledge acquisition or have had the audacity to champion our palpable family legacy of education.

I want to additionally highlight the incredible and unwavering efforts of my stellar dissertation committee, which included Dr. Sandra M. Harris and Dr. Tracey M. Phillips. I specifically chose this committee to help guide this research endeavor because of the significant contributions that these women have made to their respected fields of study and practice. Thus, I am humbled to acknowledge that these incredible African American female academics and social scientists have edified my perspective as well as shaped my identity as a Nigerian American female scholar. And last but certainly not least I could not have achieved the completion of this research without the brave and commendable participants of this study. I promised them that I would honor their experiences by relaying their narratives to the greater body of research. Their descriptive inputs have humbled me, and I will remain forever grateful for their contributions.

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# Chapter 1: Introduction to the Study

Borderline personality disorder (BPD) is a mental health condition that contributes to behavioral and emotion dysregulation of those with the condition (Homan, Sim, Fargo, & Twohig, 2017; Paris 2018). Defining features of the disorder include emotion dysregulation and repeated interpersonal relationship conflicts (Bilek et al., 2017). Children who grow up with parents who have affect regulation issues like those caused by BPD can become so emotionally drained that by adulthood, they may have learned to repress their emotional needs and subsequently may lack the energy needed to pursue intimate relationships (Gibson, 2015). Moreover, existing literature presents that children who have parents with the mental illness of BPD have been noted to have difficulties establishing and sustaining relationships with others as a result of the emotional disconnection that they experienced from their parents (Allen, 2018; Gibson, 2015).

Parents with mental illness may leave their children with a legacy of emotional, physical, or social challenges such as difficultly finding employment, challenges with parenting their own children, developing poor interpersonal skills and having dysfunctional relationships (Jackson, 2016). Researchers have found that children who have parents with mental illness are at a greater risk of developing psychosocial and mental health problems that may follow them into adulthood (Foster et al., 2012; Isobel, Allchin, Goodyear, & Gladstone, 2019; Jackson, 2016). Findings from a study by Bartsch, Roberts, Davies, and Proeve (2015) showed that children of parents diagnosed with BPD developed cognitive disturbances: self-dysfunctions: and behavioral,

emotional, and interpersonal difficulties.

Prior research has revealed that women are significantly more likely to be diagnosed with BPD than men, with women making up 75% of the diagnosed cases of BPD in the United States (Pedneault & Gans, 2018). Additionally, Pedneault and Gans (2018) reported racial/ethnic variances in the prevalence of BPD. The researchers noted the following rates of BPD among various racial/ethnic groups in the United States: 5% of Native Americans, 3.5% of Blacks, 2.7% of Whites, 2.5% of Hispanics, and 1.2% of Asians. Evidence suggests that a maternal mental disorder such as maternal BPD could have severe consequences for the functionality of a family unit, and negatively impact adult offspring's ability to form close relationships with others (Leonard, Linden, & Grant, 2018; Petfield, Startup, Droscher, & Cartwright-Hatton, 2015). However, there was a gap in the literature pertaining to how Axis II Cluster B mental illnesses like BPD affect African American mother-daughter relationships and subsequent attachment orientations in adult female offspring. Findings from this study could provide information on African American female mental health as it relates to BPD and how this personality disorder in African American mothers consequently influences the attachment patterns and interpersonal skills of their daughters.

In this qualitative transcendental phenomenological study, I investigated how the experiences of being raised by a mother diagnosed with BPD affected subsequent adult attachments for African American women. In this chapter, I provide information on the background for this study, identify the problem that was addressed in this study, discuss the purpose of the study, and present the research question for the study. I also present an

overview of the conceptual framework, describe the nature of the study, and define key terms. At the end of this chapter, I discuss the assumptions associated with the study, describe the scope and delimitations, present the limitations of the study, and consider the study's significance. I additionally provide an overall summary and a transition to the following chapters of the study.

## Background

According to the National Institute of Mental Health (2016), 43.8 million Americans aged 18 or older, or 18.2% of the U.S. adult population, have some form of mental illness. BPD affects between 6-15 million people in the United States (Aguirre & Galen, 2013). What is more, BPD has been recognized as one of the most common, burdensome, and costly psychiatric conditions; with BPD patients accounting for 20 percent of psychiatric hospitalizations (Bilek et al., 2017; Chanen, Berk, & Thompson, 2016; Hong, 2016). Researchers have noted that while BPD is not as well recognized as other disorders, it is a more common mental illness than schizophrenia, and the disorder is oftentimes misdiagnosed as bipolar disorder (Pedneault & Gans, 2018; Zimmerman, Chelminski, Dalrymple, & Martin, 2019). Women are more likely to be affected by BPD than men (Jani, Johnson, Banu, & Shah, 2016). Moreover, Tomko, Trull, Wood, and Sher (2014) found that Native American and Black women, in addition to women who were separated, divorced, widowed, or have never been married, remain at an increased risk of having the disorder.

According to Streit, Colodro-Conde, Hall and Witt (2020) BPD is comprised of a heterogeneous range of symptoms, including dysfunctional affect regulation and unstable

interpersonal relationships. Manifestations of BPD include symptoms such as unpredictability, intense interpersonal relationships, feelings of worthlessness, episodes of rage, constant fears of abandonment, an intolerance for solitude, and a lack of a secure sense of self, all of which stem from impairments in one's fundamental attachment organization (Fonagy & Bateman, 2016). Faulty attachment processes brought on by neglect and trauma in childhood have been linked to insecure attachment patterns in adulthood for people with diagnosed BPD (Mosquera, Gonzalez, & Leeds, 2014). Moreover, one of the primary characteristics of BPD is the disorder's ability to impair or negatively impact self-relation as well as interpersonal relationships (Euler et al., 2019).

BPD involves disruptions in attachment, and offspring of mothers with BPD are at an elevated risk of developing BPD themselves (Macfie, Kurdziel, Mahan, & Kors, 2017). For dyadic mother-daughter relationships impacted by maternal BPD, the formation of healthy bonding and attachment between both parties is undermined due to an abnormal connection. Neuman (2012) explained that impaired mothering relationships that result from a mother's BPD diagnosis may lead to children being confused, anxious, untrusting, and fearful. Children whose mothers have mental disorders such as BPD have been identified as being at risk for developing a range of adverse psychological outcomes such as bipolar disorder and major depressive disorder (MDD) and may even demonstrate symptoms associated with reactive attachment disorder (Cullen et al., 2014; Upadhyaya et al., 2018). Moreover, findings from a number of studies have supported the conceptual relationship between attachment insecurity,

disorganized attachment, BPD, and personality pathology (Bartsch et al., 2015; Khoury et al., 2019; Levine & Heller, 2012; Macfie et al., 2017).

BPD can be transgenerational (Hunt, Bornovalova, & Patrick, 2015). According to Hunt et al. (2015), genetics, environmental, and interpersonal experiences with parents who have BPD predispose offspring to developing BPD and/or traits of the disorder. Offspring of mothers who have emotion regulation disorders (such as BPD) have been found to be especially at risk for poor social functioning (Cullen et al., 2014; Stepp, Whalen, Pilkonis, Hipwell, & Levine, 2012). Such children also grow up being at risk for developing impulsive behaviors and antagonistic attitudes and have been found to have issues with rage, violence, hostility, depression, and affectionless psychopathy (Bowlby, 1954; Cullen et al., 2014; Gambin, Wozniak-Prus, & Sharp 2018; Kaufman et al., 2017).

According to Murphy, Peters, Wilkes, and Jackson (2018), it is crucial that adult children understand the needs, experience, and context of how parental mental illness impacts families. In a 2018 study, Greenberg, Baron-Cohen, Rosenberg, Fonagy, and Rentfrow explored the possible connection between childhood trauma and an increase in trait empathy in adulthood using multiple studies, self-report measures, and nonclinical samples. Overall results revealed that adults who narrated traumatic experiences in childhood had heightened empathy levels in comparison to adults who did not have a traumatic childhood experience (Greenberg et al., 2018). According to De Bellis and Zisk (2014), childhood traumatic experiences (i.e. childhood emotional neglect leading to insecure attachment and bonding experiences) increases an individual's ability to adopt

the perspective of another person in order to understand their psycho-emotional state. Findings from Murphy et al.'s (2018) eight-study systematic review showed that adult children with mentally ill parents sought a greater understanding of mental illness. Nevertheless, although not all children of parents with BPD will develop psychopathology, children who have mothers with BPD have been found to develop an insecure attachment to their mothers, and they remain at a greater risk for developing attachment problems that could lead to unstable relationship issues in adulthood (Bartsch et al., 2015; Levy, Johnson, Clouthier, Scala, & Temes, 2015).

Oskouie, Zeighami, and Joolaee (2011) indicated that research regarding the connection between parental mental illness and the implications for children has increased in recent years due to the potential adverse health and social outcomes for the children. Moreover, Levine and Heller (2012) found that parental BPD could be linked to what attachment theorists acknowledge as insecure attachment patterns. Arroyo and Anderson (2016) explained that attachment styles to mothers might predict the quality of an individual's future relationships as well as their ability to cultivate close relationships. The mental illness of BPD involves disruptions in attachment; consequently, offspring of mothers with BPD are at an elevated risk of developing the disorder themselves (Macfie et al., 2017). Similarly, Moscoso, Speranza, Delvenne, Corcos, and Pham-Scottez (2018) explained that the quality of primary caregiver relationships is crucial because it can generally influence the development of an individual's personality.

Gentzler, Ramsey, and Black (2015) explained that mothers' attachment patterns have been found to influence their children's attachment as well as their children's affect

regulation development. Maternal BPD has been found to negatively impact child rearing, which increases offspring risk for disorganized attachment, and thus overall predicts BPD symptoms in offspring in adulthood (Macfie et al., 2017). What is more, according to Cooley and Garcia (2012), African American women have reported holding less positive views of others compared to European American women regarding ethnic differences in attachment styles; therefore, attachment styles that encourage caution in relationships may be adaptive and normative for African American women. Securely attached individuals are believed to have the capacity to have healthy balanced interpersonal relationships (Tinsley, 2016). Those who do not have a secure attachment with one or both parents remain at a heightened risk for relationship dissatisfaction or low self-esteem, which could be a factor related to attachment style and level of satisfaction within African American relationships (Tinsley, 2016). Therefore, exploring the impact that a situational variable such as maternal mental illnesses has on African American adult female offspring attachments patterns is imperative for expanding knowledge and contributing to literature on African American adult attachment patterns.

## Problem Statement

De Genna and Feske (2013) found that African Americans are more likely to experience mental disorders than individuals from other racial and ethnic groups in the United States. Data published by the U.S. Department of Health and Human Services Office of Minority Mental Health (2016) showed that Black/African American adults are 20% more likely to report severe psychological distress than Caucasian/White adults. According to the National Alliance on Mental Illness (2016), African Americans have

trouble identifying signs and symptoms associated with mental health conditions. Consequently, African Americans are less likely to seek treatment for mental illness than other groups (Struggs & Harris, 2016). What is more, according to the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*) cultural variations in symptoms and descriptive models associated with these cultural concepts may lead clinicians to underestimate the severity of a mental health issue or misdiagnosis clients (American Psychiatric Association, 2013).

African Americans account for nearly 25% of the mental health cases in the United States, even though they make up only 13.4% of the national population (Leary, 2013). According to Nelson, Cardemil, and Adeoye (2016), the mental health-seeking behaviors of African American women may be partly diminished due to the "strong Black woman" (SBW) myth. This social construct perpetuates the notion that African American women are strong, nurturing women who must silently "deal with" manifestations of mental illness rather than seek professional treatment (Nelson et al., 2016). Nelson et al. further posited that African American women may socialize their daughters to become strong Black women to preserve this social archetype. Woods (2013) found a significant positive relationship between the endorsement of the SBW myth and elevated levels of depression in African American women. Woods also found that the strong advocacy of the SBW myth was significantly related to lower intentions to seek mental health treatment among African American women.

Norris and Mitchell (2014) explained that African American women tend to avoid mental health treatment and accept anxiety as a normal part of life for Black women.

Research findings have revealed that because African American women are disproportionately more likely to experience social circumstances that increase their chances for acquiring mental illness (e.g., racial microaggressions), they are less likely to use mental health services (Brown, 2017; Moody & Lewis, 2019). Moreover, researchers found that experiences of racism and other forms of indignities can adversely impact emotion regulation in Black women (Graham, Calloway, & Roemer, 2015). Nevertheless, while they experience a number of illnesses at disproportionate rates, African Americans, particularly African American women, are frequently misdiagnosed in clinical practice, and consequently remain understudied, underserved, and underrepresented in clinical research (Carr, Szymanski, Taha, West, & Kaslow, 2014; George et al., 2014). In the same way, the pervasive ideology of the SBW archetype in Black culture has been found to discourage Black/African American women from expressing healthy emotional responses (Clement et al., 2015; Nelson et al., 2016; Stanton, Jerald, Ward, & Avery, 2017; Thoits, 2013). With much of mental health remaining dependent on societal reinforcements, researchers have found that the SBW social construct is preventative factor in the mental health treatment-seeking behaviors of African American women; this reluctance of seek treatment can challenge African American women's ability to properly connect with their children, families, and loved ones (Abrams et al., 2014; Lewis, Mendenhall, Harwood, & Huntt, 2013).

According to the National Institute of Mental Health (2016), many African Americans have trouble recognizing signs and symptoms associated with mental health conditions, which in turn leads to underrating the influence and impact of issues related

to mental health. However, although African American adults have been found to be more likely to report serious psychological distress associated with mental health problems than adult Whites, only approximately one quarter of African Americans seek mental health treatment when experiencing a mental health crisis (American Psychiatric Association, 2017; Mental Health America, 2016). Similarly, the American Psychiatric Association (2017) reported that African Americans are approximately twice as likely as non-Hispanic whites to be diagnosed with serious mental illnesses like schizophrenia.

According to Raley, Sweeney, and Wondra (2015), racial and ethnic differences in relationship patterns (e.g., marriage patterns) show that Black/African American women tend to marry later in life, are less likely to marry at all, and have higher rates of marital instability compared to both White and Hispanic women. Additionally, researchers found that although Black/African American women had fewer reported marriages than other racial/ethnic groups, African American women place a high value on marriage despite the higher rate of single motherhood among African American women (Raley et al., 2015; Tinsley, 2016). Furthermore, individuals who were separated or divorced have been found to have the highest rates of personality disorders (Quirk et al., 2016). Ultimately, these findings could lend to the potential indication of attachment issues.

Early attachments form an individual's internal models of how to build and sustain relationships (Streep, 2017). Mother-daughter relationships have higher levels of interdependency and emotional intensity than other relationships (Everet alt, Marks, & Clarke-Mitchell, 2016) Furthermore, evidence suggests that daughters run the risk of

unintentionally replicating negative maternal relationship bonding styles in other interpersonal relationships (Streep, 2017). While existing literature has amply focused on the deleterious impact of maternal BPD on children and the ensuing risk of children developing problematic psychosocial issues and maladaptation (Bartsch et al., 2015; Groh, Fearon, van IJzendoorn, Bakermans-Kranenburg, & Roisman, 2017; Macfie et al., 2017); important unanswered questions remain regarding how mother-daughter attachment experiences associated with maternal BPD influenced adult attachment patterns and the ability to form meaningful relationships for African American women. Therefore, this study will address a gap in the literature by exploring how the lived experiences of having a mother diagnosed with BPD influenced adult attachment for African American; and how their maternal attachment experiences impacted their adult attachment patterns, their views on close relationships and their abilities to form meaningful relationships.

## Purpose of Study

The purpose of this qualitative, transcendental phenomenological study was to explore how the experiences of being raised by a mother diagnosed with BPD affected subsequent adult attachments for African American women. According to Elliott, Powell, and Brenton (2015), the mother-daughter relationship is a bond that is crucial for self-esteem building and psychosocial development for girls. Researchers suggest that the absence of secure maternal attachment can influence daughters in a multitude of adverse ways, including how adult daughters view, establish, and relate to others within interpersonal relationships (Balsam & Fischer, 2014; Streep, 2017). A mother with BPD

can negatively impact their child's development of a secure healthy emotional base and in turn leave the child without a healthy example of intrapersonal expressions and interpersonal functioning (Kaufman et al., 2017; Petfield et al., 2015). However, despite an abundant amount of research addressing adverse psychosocial outcomes for offspring associated with having a mother with BPD, and research that has examined the characteristics and variable construction of BPD in different racial/ethnic groups (De Genna and Feske, 2013), there remained a gap in knowledge regarding how maternal BPD impacts the attachment patterns of African American women. The present study sought to examine African American women and their relationships with their mothers because, according to Balsam and Fischer (2014), mother-daughter relationships significantly influence how daughters view themselves as well as how they form connections with others. Moreover, Infurna et al. (2016) explained that insecure mother-child attachments could predispose offspring to emotion dysregulation and poor social skills, which could lead to problems with developing relationships with others later in life.

According to Dow (2016), African American women are largely influenced by cultural expectations of motherhood. Moreover, Baugh and Barnes (2015) revealed that the mother-daughter relationship, specifically the Black mother-daughter relationship, influences the development of overall esteem in Black daughters. Previous researchers explained that early attachment security between African American mothers and their daughters was related to lower risky behaviors in their daughters (Lockhart et al., 2017; Massey, Compton, & Kaslow, 2014). Clinical studies on BPD have highlighted the role

insecure attachment and how this disarranged connection can lead to disrupted interpersonal relationships (Miljkovitch et al., 2018; Sharp et al., 2016). Yet, to date, no researcher has specifically examined how early attachment experiences may have influenced current patterns of adult attachment in African American women who have mothers diagnosed with BPD, according to my review of the literature.

## Research Question

I sought to answer the following research question: How did the experiences of being raised by a mother diagnosed with borderline personality disorder (BPD) affect subsequent adult attachments for African American women?

## Conceptual Framework

I used principles of Bowlby's (1969) attachment theory as well as Bartholomew and Horowitz's (1991) four-category model of adult attachment as the foundational theoretical principles for my examination of attachment experiences associated with having a mother with BPD, and how these experiences influenced current patterns of relationship attachment for African American women. A brief overview of each theory is presented in the paragraphs that follow. Additional information on attachment theory and the four-category model of adult attachment is presented in Chapter 2.

Attachment theory. Bowlby formally introduced attachment theory in 1969. The psychoanalytical theorists defined attachment as a "lasting psychological connectedness between human beings". Bowlby further suggested that mental representations of a child's first attachment experiences with the primary caregiver shaped the child's future relationships (Bowlby, 1969). A major premise of attachment theory posits that children

who form strong attachments to a parent/primary caregiver are more likely to develop healthy attachment styles in adulthood (Bowlby, 1969).

Four-category model of adult attachment. Bartholomew and Horowitz (1991) categorically identified four attachment modes for adult relationships (secure, insecure anxious-preoccupied, insecure dismissive-avoidant, and insecure fearful-avoidant). As a result, the adult attachment theorists found that attachment patterns between adults shared similar characteristics to attachment patterns between children and caregivers (Bartholomew & Horowitz, 1991). One of the primary characteristics of BPD is that the disorder negatively impacts an individual's ability to develop healthy interpersonal relationships (Crowell, 2016). BPD disturbs the attachment bond between mother and offspring and may in turn lead to an abnormal pattern of attachment between them (Macfie et al., 2017; Miano, Grosselli, Roepke, & Dziobek 2017). The goal of this study was to explore how the experiences associated with being raised by a mother diagnosed with BPD impacted subsequent adult attachments for African American women. Therefore, principles of the attachment theory and the four-category model of adult attachment were appropriate for guiding this research. Additional details on attachment theory and the four-category model of adult attachment will be presented in Chapter 2.

## Nature of the Study

I used a qualitative, transcendental phenomenological approach to explore how the experiences of being raised by a mother diagnosed with BPD affected subsequent adult attachments for African American women. The transcendental approach to qualitative phenomenology requires researchers to collect data that illuminates the

quintessence of human experiences (Martirano, 2016). The transcendental phenomenological design was particularly suited for this study because transcendental phenomenology allows researchers to focus less on the subjective interpretations of the phenomenon and more on participant experiences and their descriptions of an experience (Kafle, 2013). Therefore, the use of the transcendental phenomenological approach was well suited for exploring how having a mother diagnosed with BPD affected the subsequent adult attachment patterns in African American women.

Purposeful sampling along with snowball sampling was used to recruit participants for this study. Palinkas et al. (2015) explicated that purposeful sampling is commonly used in qualitative research in order to recruit viable cases related to the phenomenon being studied. In addition, snowball sampling is a non-probability sampling method where participants in a study can recruit other potential participants from among their associates (Palinkas et al., 2015). The sample included African American women between the ages of 18 and 45 who have the shared experience of having a mother who was diagnosed with BPD. Participants completed semi-structured-interviews that were guided by open-ended questions. Microsoft Word and Microsoft Excel were used to organize the collected data and aid in the data analysis.

## Definitions

In this study, the terms *African American* and *Black* are used interchangeably**.** I also use the following key terms throughout this study; therefore, it is necessary to define their meanings in the context of the study:

*Adult attachment*: The psychological and emotional bond within adult relationships including friendships, familial, romantic, or platonic relationships (Hooley & Wilson-Murphy, 2012; Padilla-Walker, Memmott-Elison, & Nelson, 2017).

*Affectionless psychopathy*: A condition where an individual is unable to demonstrate empathy, affection, or other caring behaviors for others (Gambin et al., 2018).

*Attachment*: The lasting psychological and emotional bond between human beings (Bowlby, 1969; Waters & Sroufe, 2017).

*Borderline personality disorder (BPD)*: A mental illness marked by an ongoing pattern of erratic moods, unstable emotional states, distorted self-image, and impulsive or risky behavior, according to the *DSM-5* (American Psychiatric Association, 2013; see also National Alliance on Mental Illness, 2017).

*Insecure attachment*: A relationship style where the bond between two or more individuals is laden with fear, avoidance, anxiety, preoccupation, and dismissiveness that detrimentally affect one or all relationship participants (Ainsworth, 1989; Briere, Runtz, Eadie, Bigras, & Godbout, 2017).

*Maternal deprivation hypothesis*: A hypothesis by Bowlby (1954) that suggests constant disruptions of the attachment bond between a primary caregiver (typically the mother) and an infant results in a disordered attachment that predisposes the child to a host of social, emotional, and psychological disturbances.

*Meaningful relationship*: A relationship that holds significance and importance to an individual (Thompson, 2015).

*Mentalization*: A psychological term that refers to an individual's ability to understand their mental state, the mental state of others, and ultimately comprehend one's own and others' intentions and affects (American Psychological Association, 2018).

*Secure attachment*: A bond between two or more individuals where participants of the relationship feel secure, connected, and supported (Bowlby, 1969).

## Assumptions

The purpose of this study was to use a transcendental phenomenological approach to explore how the experiences associated with being raised by a mother diagnosed with BPD affected subsequent adult attachments for African American women. Because the targeted population of participants for the study was African American women who have mothers diagnosed with BPD, a major assumption associated with this research was that participants would be aware and honest in the fact that their mothers have been formally diagnosed with BPD. Furthermore, I expected that I would be able to recruit African American female participants who were willing to share their challenges and the impact of their mother-daughter experiences associated with the phenomenon.

I assumed that the inclusion criteria for the sample was appropriate for assuring that all participants would have had the same or similar experiences with the phenomenon of interest. I also held the assumption that participants would have a genuine interest in participating in my research and would not have any other motives other than sharing their experiences. Another assumption I held as the researcher was that the African American female participants would be honest in their accounts and reports of their attachment experiences. Additionally, I presumed that participants would

provide candid narratives of having a mother with a BPD diagnosis and how this experience shaped their ability to form intimate connections as adults.

## Scope and Delimitations

Several theoretical perspectives related to attachment theory were considered as the orientation for guiding this study. One such example is the object relations theory. Founded by Abraham in 1927 and modernized in by Melanie Klein, the object relations theory proposes that the relationships that people have with their family, particularly that between mother and child, determines an individual's personality (Flanagan, 2011). Additionally, object relations theory suggests that family experiences in infancy shape the way that individuals form relationships and handle situations in adulthood (Flanagan, 2011). Concepts from both object relations theory and attachment theory provide a framework for explaining how the quality of attachment between mother and child affects the child's quality of later attachments with others. Although both theories are closely related and can be used in conjunction with one another, I found attachment theory more closely explained how failed early attachments could impact later adult attachments.

Another theory that I considered for this research was Homans' social exchange theory. Initially proposed in 1958, Homans suggested that individuals invest time and energy into a relationship only when they perceive that they will benefit from it (Cook, Cheshire, Rice, & Nakagawa, 2013; Homans, 1958; Shahsavarani et al., 2016). However, the premises of social exchange theory would not have allowed me to explore how study participants' early interactions with their mothers aided in the development of their attachment patterns, social engagements, and interpersonal interactions as adults.

As a result, I concluded that attachment theory would provide the best theoretical founding for guiding my research.

The boundaries of this study included African American female participants between 18 and 45 years of age. An additional boundary for this study was the online and social media recruitment setting for the study that ultimately provided as limited participant recruiting avenues. Participants were recruited from online support communities that specifically provide support to family members who have relatives diagnosed with BPD, online groups that promote mental health wellness for Black/African American women, and online communities that provide networking opportunities for current and aspiring minority doctors in professional fields including but not limited to medicine, psychology and family studies. Because I recruited only African American women from Black/African American female mental health wellness groups, online mental health and BPD family support groups, and groups for minority working professionals, the general population of non-African Americans and adult males with mothers who have BPD in the United States was not represented by this sample. Eleven participants who were African American adult daughters of mothers diagnosed with BPD participated in this study ($n$=11). Although results from the study may have the potential to be transferable, the sample size and inclusion criteria of this study could limit the transferability of results to other contexts or settings.

## Limitations

Limitations associated with utilizing a phenomenological design for this study include a small sample size, the possibility that participants may not be willing or able to

clearly express their experiences to the researcher, and the possibility that researcher bias may influence the data collection and interpretation (Lewis, 2015). A limitation of this study included the study's exclusivity to African American women in the United States who have mothers who have been diagnosed with BPD. Therefore, results from this study may not apply to other research contexts, settings, or women of other racial/ethnic groups. Another limitation included the study's chosen research design, which limited the study to seeking outcomes that specifically highlighted the experiences of African American women.

Although I am an African American woman with knowledge of major stigmas and negative perceptions that African Americans hold towards mental illness, my personal biases did not influence data collection or interpretations of the data. I used techniques such as bracketing and reflexive journaling to control researcher bias. I also provided additional details on the research design, data collection, and techniques that I used to control researcher bias in Chapter 3.

## Significance

This study is unique because it addressed the topic of maternal BPD and the impact it has had on adult attachment for African American women with mothers who have borderline personality disorder. Insights gained from this study could present information related to female attachment outcomes for African American women who have mothers with BPD. Social change implications include the possibility of human and social services workers and mental health professionals using information from this study to educate others on how maternal BPD affects later adult attachment for African

American women whose mothers were diagnosed with BPD. Counselors and clinicians could also use the information provided by this study to aid female clients in understanding how their early exposure to their mothers' illness may have affected their ability to form attachments with others as well as their views on intimate relationships and mental health. In turn, professionals could use the information as evidence of the need for developing brochures, guides, fact sheets and educational seminars that explain how parental BPD affects the psychosocial development their offspring. Additionally, the increased knowledge and awareness may result in African American women seeking therapeutic treatment to help them work through any attachment issues that they may be experiencing as adults.

## Summary

Chapter 1 included information on how BPD in parents can detrimentally impact their offspring and predispose their children to a host of social, emotional, physical, and interpersonal challenges. Research findings have revealed that African Americans are more likely to experience mental disorders than individuals from other racial and ethnic groups, and that African American women are more susceptible to mental disorders like BPD (De Genna & Feske, 2013**;** Lacey et al, 2015). The theoretical foundation that was used to ground this study was John Bowlby's (1969) attachment theory. Additionally, the four-category model of adult attachment conceptualized by subsequent attachment theory researchers Bartholomew and Horowitz (1991) was used to guide this study. The goal this study was to determine how experiences associated with being raised by a

mother diagnosed with BPD impacted subsequent adult attachments for African American women.

I used semi-structured interviews to collect data pertaining to the experiences of 11 African American women who have mothers diagnosed with BPD. I assumed that there would be access to participants who were able and prepared to share their experiences with the identified issue in a truthful and candid manner. Limitations anticipated in the study included a small sample size, biases in data collection and interpretation, the straightforward nature of information, and the possibility that participants may not be able to clearly articulate and express their experiences. This study is significant because it could contribute to the body of culturally based research on BPD, and provide helpful information for therapists and mental health service providers to better support African American women and families affected by emotion dysregulation disorders in the United States.

In Chapter 2, I will provide information on Bowlby's (1969) attachment theory and how it has been applied in previous research to examine the relationship between childhood early attachment to one's primary caregiver and their ability to bond with others and form meaningful relationships in adulthood. I will also review literature on Bartholomew and Horowitz's (1991) category model for adult attachment. I will then review the current literature on BPD, maternal BPD, and mental illness perceptions guided by the SBW conceptual ideology among African American women in the United States. The literature on the relationship between African American daughters and their

mothers, the relationship between mothers with BPD and their offspring, and BPD in America will also be reviewed.

# Chapter 2: Literature Review

## Introduction

Researchers have indicated that offspring of parents who have a mental illness may find it challenging to find careers, form healthy attachment styles in adult relationships, and parent their own children (Aguirre & Galen, 2013; Jackson, 2016; National Institute of Mental Health, 2016). With 75% of BPD cases affecting women, literature findings on maternal BPD suggests that offspring who have mothers with a personality disorder, such as BPD, are at a high risk of developing insecure attachments to their mother (Lawson, 2016). Moreover, Bartsch et al (2015) explained that although not all offspring of parents with BPD will develop mental or behavioral disorders, they are at a higher risk for developing problematic attachment patterns that could lead to unstable relationships in adulthood.

Having a parent with a mental illness may be especially problematic for African American offspring and their development because of the imminent systematic socioethnic challenges that may already await them once they mature into adulthood (Assari et al., 2018; Clark, Salas-Wright, Vaughn, & Whitfield, 2015). These socioethnic challenges include but are not limited to discrimination, poverty, exposure to crime, increased risk of incarceration, inadequate access to healthcare, and disjointed family dynamics (i.e., high rates of out-of-wedlock births and absent fathers), as well as interpersonal problems (Assari et al., 2018; Clark et al., 2015; Clement et al., 2015; Judd, 2018; Taylor, Forsythe-Brown, Taylor, & Chatters, 2014; Wilson, Henriksen Jr., Bustamante, & Irby, 2016). Thus, research on how adult attachment outcomes for

African American women were impacted by a maternal mental illness like BPD could contribute to mental health literature concerning African American women as well as expand family studies research on African American mother-daughter relationships.

In this chapter, I will review the literature on personality disorders, BPD. After describing the literature search strategy and conceptual framework for the study, I will review the prevalence of personality disorders in the United States and examine BPD literature for African American women compared to other racial groups. I will then present literature related to BPD and sociobehavioral, developmental, and attachment outcomes for offspring who were raised by mothers diagnosed with BPD. After doing so, I will review literature on the perceptions of Black adult women on how their mothers impact their overall self-perception. Finally, I will review literature on mental health treatment-seeking attitudes among African American women, including how the SBW social construct impacts these mental health-seeking behaviors. This chapter will conclude with a summary of the findings from the literature and a transition to the next chapter in this dissertation, which will be the research methodology that was used in this study.

## Literature Search Strategy

The research strategy I used to gather sources for this review included an extensive search of sources using the Walden University online library, the Internet, and Google Scholar. Articles were accessed using several databases and scholarly journals, which included EBSCOhost, ProQuest Central, PsycArticles, PsycINFO, Social Work Abstract, SocINDEX, *Journal of Black Studies and Research*, Black Studies Center,

JSTOR, ScienceDirect, PsychNet, SpringerLink, SpringerOpen, SageJournals, Nursing & Allied Health, Science Database, Science Direct, SAGE, Wiley, and Academic Search Premier. When exploring literature related to parental mental health and offspring outcomes as well as literature on BPD, I used terms that included *BPD*, *maternal BPD*, *borderline personality disorder and offspring outcomes*, *adult children of mothers with BPD*, *BPD in America*, *depression in African American women*, *borderline personality disorder and mental illness*, *mood disorders in African American women*, *African American women and BPD*, *borderline personality disorder and mother-daughter relationships*, *African America women and African America mothers and depression*, *Black women and emotional regulation*, and *African American and black women and mental illness*.

I also searched for literature related to mother-daughter relationships using keywords that included *affective behavior in mother-daughter dyads*, *black mother-daughter relationships*, *African American women*, *African American mothers*, *African American mother-daughter relationships*, *African American women lived experience*, *African American mothers of Black women and affect disorders*, *strong Black woman (SBW)*, *young adult and parent interactions*, and *mental illness and mother-daughter relationships*. Lastly, while searching for articles pertaining to literature related to the conceptual orientation of this study and other elements of attachment, I researched terms such as *attachment theory*, *adult attachment styles*, *attachment theory and children with BPD mothers*, *disorganized attachments*, *John Bowlby*, *Mary Ainsworth*, *Cindy Hazan and Phillip Shaver*, *Kim Bartholomew*, *Leonard Horowitz*, *Karpman Drama Triangle of*

*codependency and BPD*, *Dark Triad and borderline personality disorder*, *Vulnerable Dark Triad and borderline personality disorder*, *African American women attachment styles*, *attachment security in African American women*, *African America women low marriage rates*, *Black women and insecure attachment*, and *African America women and African American mothers and single parenthood*. These keywords were used individually or in pairs and then combined to form key phrases. Reference lists from some of the articles located and retrieved were also searched. I chose articles from selected references based on their relevance to the study, giving preference to peer-reviewed scholarly articles and books. In total, this literature review included 210 scholarly sources, with an overall total of 313 scholarly references that supported this study.

## Conceptual Framework

The conceptual framework I used to guide this study was attachment theory and along with four-category model of adult attachment. In 1969, British psychologist and psychoanalyst Bowlby assumed that early attachment experiences could have a lasting impact across an individual's lifespan (Bowlby, 1969, 1977, 1982). Through his work with providing therapeutic intervention for emotionally disturbed children, Bowlby came to believe that psychological, emotional, and behavioral problems could stem from disorganized early childhood attachment experiences.

### Attachment Theory

Attachment theory posits that during the early interactions between child and caregiver, an emotional bond develops that affects how the identity development,

intrapersonal regulation, and attitudes of a child are formed (Bowlby, 1969). According to Bowlby, a child has an innate desire to attach to a main attachment figure (Bowlby, 1969). Although Bowlby acknowledged that a child could have various attachment figures, he observed that a child's primary bond, which was typically between mother and child, was the most crucial element for an individual to form healthy attachment patterns later on in life. Bowlby (1969) explained that children's attachment rapport with their primary caregivers precedes the formation of their internal working model. Bowlby defined an individual's internal working model as the psychological framework that encompasses how they come to understand themselves, others, and the society in which they live (Bowlby, 1969; Klass, 1988). Thus, the threat of maternal deprivation can detrimentally impact the child's ability to subsequently develop a healthy attachment bond with their primary caregivers (Bowlby, 1954).

Bowlby (1954) suggested in his maternal deprivation hypothesis that the recurrent disruption of the attachment bond between an infant and primary caregiver (i.e., the mother) could yield enduring social, emotional, and cognitive disturbances for the infant. Social, emotional and psychological consequences that stem from emotional deprivation include delinquency, increased aggression, depression, and reduced intellectual functioning (Bowlby, 1954). Furthermore, Bowlby proposed that when a primary attachment figure fails to establish a secure base for the child by means of maternal deprivation, the child becomes predisposed to negative consequences including affectionless psychopathy (Bowlby, 1954).

Bowlby (1977) posited that the attachment bond between parent/caregiver and child is a multifaceted system of behavior that serves to protect children from danger while they seek security from their primary caregivers. Bowlby further explained that such a bond could be a source of encouragement during challenging times and promote self-esteem development in the child. He theorized that the attachment bond between children and their caregivers is contingent upon two factors: (a) the caregiver's ability to meet the biological and psychosomatic needs of the child and (b) the caregiver's ability to be trustworthy, empathetic, loving and caring. Ultimately, Bowlby conceptualized that those who developed insecure attachment orientations in childhood could find themselves mentally disconnected from others in later years, which he identified as a common issue for those who have personality disorders. As a result, Bowlby (1977) hypothesized that insecure attachments and bonds could later lead to personality disorders.

**Attachment types and the four-category model of adult attachment.** In addition to Bowlby, other theorists such as Ainsworth (1989), Bartholomew and Horowitz (1991) and Hazan and Shaver (1994) have contributed to the study of human attachment. These researchers addressed the different styles of attachment that can be observed among child and primary caregiver and adult interpersonal relationships. According to Ainsworth (1989), attachment style refers to the state and quality of an individual's connections with others. Ainsworth categorized attachments as being either secure or insecure. Insecure attachments were classified as insecure-avoidant, insecure-ambivalent, and insecure-disorganized to describe insecure attachment styles between children and their primary caregivers (Ainsworth, 1989). When an individual feels a

sense of attachment, they ultimately feel secure (Ainsworth, 1989). Alternatively, an individual who is insecurely attached can have a combination of feelings towards their attachment figure such as codependency, fear of rejection, and/or peevishness (Ainsworth, 1989).

Attachment behavior is described as any form of behavior that results in an individual gaining or regaining a sense of closeness to someone who they prefer to be in proximity (Ainsworth, 1989). Ainsworth explained that such behavior is prompted by separation or the threat of separation from an attachment figure. Both attachment style and attachment behavior are grounded in an individual's internal working model of attachment: which is described as a person's ability to effectually control emotions by the formation of attachment representations (Ainsworth, 1989). This internal working model of attachment suggests that attachment patterns pertaining to individuals, their significant others, and their interpersonal relationships can be identified through this model of attachment (Ainsworth, 1989). Moreover, considerable evidence suggests that infant attachment patterns endure well into middle childhood and ultimately into adulthood (Holmes, 2014a).

During the early years of attachment theory development, one of the main limitations of the theory was that it had been characteristically and exclusively studied in the context of young children and their primary caregivers (Fraley & Roisman, 2018). Bartholomew (1990) provided an interpretation of two key fundaments of self-report amounts of attachment style: anxiety (pertaining to separation, abandonment, insufficient love) and avoidance (pertaining to intimacy, dependency, emotional, expressiveness).

Shortly after, Bartholomew and Horowitz (1991) introduced a four-category model for adult attachment (secure, anxious-preoccupied, dismissing-avoidant, and fearful-avoidant). The four representative attachment patterns outline the combinations of an individual's positive or negative self-image and their positive or negative image of others (Bartholomew & Horowitz, 1991). Bartholomew and Perlman (1994) suggested that people with positive models of self and others are secure within self as well as secure within their attachment orientation. They further explained that those with positive models of others and negative models of self are preoccupied, people with negative model of others but a positive view of self are dismissing, and those with negative models of both self and others are fearfully avoidant (Bartholomew & Perlman, 1994).

**Attachment Styles**

Attachment theorists described adult attachment styles as a collection of knowledge, beliefs, and insecurities that adults hold about themselves and their close relationships (Hazan & Shaver, 1994). Attachment styles reflect the views that individuals hold about themselves and others, and can considerably influence the quality of adult relationships as well as have an impact on one's mental wellness and their identity (Sirois, Millings, & Hirsch, 2016). Outlooks on attachment patterns and behaviors are a result of life experiences that individuals have shared with their caregivers, and can influence the way in which adults perceive and act within intimate interpersonal relationships (Ahmed & Brumbaugh, 2014; Holmes, 2014a; Sirois et al., 2016). In turn, attachment researchers discovered that individuals in relationships where

both parties had weak attachment patterns shared feelings of inadequacy and a lack of intimacy with their partners (Hazan & Shaver, 1994).

Contemporary attachment theorists have hypothesized that an individual's attachment history stemming from childhood has an enduring effect on their relationship skills in adulthood (Holmes, 2014a; Mesman, Van Ijzendoorm, & Sagi-Schwarz, 2016). A number of studies on parent-child attachment have determined that securely attached children adopt effective emotion regulation strategies within the parent-child attachment relationship, which provides them with useful affect control strategies that they can utilize outside of the attachment relationship that they share with their parent (Brumariu, 2015). Furthermore, researcher findings indicate that individuals who have secure attachments tend to have positive views of themselves as well as have the propensity to seek intimacy and nearness with others (Tinsley, 2016).

**Secure attachment.** Secure-autonomous attachment characterizes people who are comfortable with intimacy and autonomy (Ainswioth, 1989; Bartholomew & Horowitz, 1991; Konrath, Chopik, Hsing, & O'Brien, 2014). Securely attached people have a lower avoidance rates and lower anxiety, and have a strong capacity to co-regulate (Brumariu, 2015; Green & Douglas, 2018). They are not worried about rejection nor are they preoccupied with their relationships. Those who are securely attached typically hold positive views of themselves and positive views of others (Ainsworth, 1989). Some key attributes of secure-autonomous individuals include: (a) their ability to be comfortable within an emotionally close relationship; (b) they can receive and reciprocate dependability within an intimate relationship; (c) they can be close with their partner but

also see them as an independent individual; (d) they are empathetic, forgiving, tolerant of individuality and trusting; and (e) they can regulate their emotions when dealing with relationship issues. Children of securely autonomous adults typically develop the same attachment style even into adulthood (Konrath et al., 2014).

A considerable amount of literature has examined the connection between attachment style and emotional responses (Pietromonaco & Beck, 2015). According to Pietromonaco, DeBuse, and Powers (2013), individuals who form expectations, beliefs, and desires about close relationships based on childhood attachment experiences with caregivers are typically open to revising those internal working models of attachment based on experiences in later intimate relationships. What is more, researchers suggest that an individual's past relationship experiences can even guide the way that they interpret events in their current romantic relationships (Pietromonaco et al., 2013). Batinic, Milosavljevic, and Barisic (2016) conducted a quantitative study that examined the effect of attachment styles on romantic love (RL). Attachment style was assessed by the Experience in Close Relationships Scale (ECR-R), and the components of RL by the Sternberg's Triangular Love Scale (scale measures the three components of love: passion, intimacy and commitment). Results of the study showed that people with secure attachments reported a greater level of intimacy in romantic love in comparison to people with preoccupied and dismissive attachment styles. The authors concluded that people with secure attachment patterns achieved the highest levels of intimacy in romantic love, while those with insecure attachment patterns experienced the low levels.

**Insecure attachment.** According to Mikulincer and Shaver (2019), individuals who are insecurely attached oftentimes have early attachment experiences that involve unstable and poor distress regulation. Attachment insecurity can negatively affect an individual's physical, social, and mental health, and detrimentally impact their interpersonal relationships by causing them to detach form natural attachment needs, emotions, and behaviors (Holmes, 2014b). Moreover, attachment researchers hypothesized that those who have insecure anxious-preoccupied, dismissive-avoidant, fearful-avoidant attachment orientations have a difficult time being close to others and are typically struggle with emotionality and establishing secure connection within intimate relationships (Bartholomew & Horowitz, 1991; Holmes, 2014b).

**Anxious-preoccupied**. Individuals with anxious attachment styles tend to experience failed relationships as well as suffer from psychological problems (Ein-Dor, Mikulincer, Doron, & Shaver, 2010). Anxious-preoccupied adults are known to value and desire intimate relationships and connections, yet they may be insecure about as well as within relationships (Bartholomew & Horowitz, 1991; Holmes, 2014b). Researchers posit that an anxious-preoccupied person's excessive need to be close to others can discourage others from maintaining relationships with them (Bartholomew & Horowitz, 1991; Holmes, 2014b; Palagini, Petri, Bacci, Caruso, & Perugi, 2017). Adults who have anxious-preoccupied attachment styles tend to be insecure within intimate relationships, and tend to constantly worry about abandonment and rejection (Holmes, 2014b). Anxious-preoccupied people may described as "needy", may require a constant guarantee about their relationship, and may be hypersensitive to their partner's moods and actions

(Bartholomew & Horowitz, 1991; Holmes, 2014b). Adults with this attachment orientation can also be emotional and can at times be confrontational, antagonistic, irate and domineering, and lack perception of personal boundaries when they believe that their relationship is in jeopardy (Holmes, 2014b). Additionally, people with anxious attachment patterns and behaviors can have unpredictable moods, may feel comfortable starting arguments, tend to have poor communication skills, and may avoid taking responsibility when confronted with relationship issues (Palagini et al., 2017).

**Dismissive-avoidant**. Adults with a dismissive-avoidant attachment style exhibit a high degree of avoidance behaviors (Winterheld, 2016). These individuals tend to avoid getting involved in intimate relationships. They may associate intimacy and dependency with the absence independence, and prefer individual freedom rather than closeness with others (Bartholomew & Horowitz, 1991; Holmes, 2014b; Winterheld, 2016). When adults with a dismissive-avoidant attachment style have close relationships, Winterheld (2016) explained that establishing bonds can be challenging for them. Moreover, such individuals tend to lack concern about their partner's availability (Bartholomew & Horowitz, 1991; Holmes 2014b). Individuals with a dismissive-avoidant attachment orientation tend to be emotionally distant and rejecting within intimate relationships, and tend to detach from natural attachment needs, emotions, and behaviors (Bartholomew & Horowitz, 1991; Holmes 2014b). Moreover, attachment researchers explained that people with this attachment style can have a difficult time expressing their emotions, typically avoid conflict, and characteristically prioritize their autonomy over building and relaying on relationship security.

**Fearful-avoidant**. Adults who have a fearful-avoidant attachment style tend to be both highly avoidant and highly anxious (Bartholomew & Horowitz, 1991; Fox, 2013; Spence, Jacobs, and Bifulco, 2018). People with a fearful-avoidant attachment orientation typically have a negative self-perception and hold negative views of others (Bartholomew & Horowitz, 1991; Spence et al, 2018). These individuals can be generally apprehensive or even intolerant of receiving and reciprocating affection and emotional intimacy. These avoidances are due to their intense sensitivity to rejection, fear of abandonment, difficulty trusting others, and poor view of self (Fox, 2013; Söllner et al., 2018). According to attachment researchers, people with fearful-avoidant attachment patterns and behaviors tend to be concerned about the commitment of their partner, and worry that if they become emotionally vulnerable within their relationship, their partners may take advantage of them or even hurt them (Bartholomew & Horowitz, 1991; Fox, 2013; Holmes, 2014b). They may also have a difficult time controlling their emotional responses by demonstrating belligerent or aggressive behaviors (Fox, 2013; Söllner et al., 2018).

## Attachment and Borderline Personality Disorder

Attachment theory has been long used to study how the caregiver-child bond shapes attachment patterns in children, and how this relationship influences children's ability to form attachment bonds in adulthood. According to Levy et al. (2015), premises of attachment theory can be used to explain how early connections with primary caregivers influences peoples' ability to establish and maintain close interpersonal relationships later in life. Researchers who study BPD have theorized that people with

BPD often have a history of emotional abandonment and/or childhood trauma (Holmes, 2014a; Levy et al., 2015). What is more, empirical evidence has shown that people with BPD and subclinical borderline features typically have a difficult time with trusting others, characteristically have insecure attachment styles, and many of those attachment styles have been classified as preoccupied and dismissive (Holmes, 2014a; Masland & Hooley, 2019).

Hill et al. (2011) conducted a study that explored attachment, relationship dysfunction, and BPD in two samples: a community sample of women, and a psychiatric sample of women. Findings from both samples showed that insecure attachment and intimate relationship dysfunction was linked to BPD symptoms. These study findings support the correlation between BPD and insecure attachment (Hill et al., 2011). Clear and Zimmer-Gembeck (2017) explained that prior research on attachment theory and emotion regulation suggests that affect regulation could be linked to adult attachment patterns. The authors examined links between attachment representations and emotion specific (sadness, worry, and anger) emotion regulation among participants between the ages of 16 to 23 (M ¼ 19.6, SD ¼ 1.58). Participants for this study were randomly assigned to report emotion regulation following insecurity priming or no priming. Three hundred and eighty-three student participants (181 male, 202 female) completed a self-report questionnaire. Multivariate regression results examining all attachment orientations concurrently showed that attachment anxiety was associated with greater dysregulation (sadness, worry, and anger) and also anger suppression. In contrast, attachment avoidance was linked to greater suppression (sadness and worry), but also

anger dysregulation. Attachment security was associated with less dysregulation (sadness, worry, and anger), and less sadness and worry suppression. The results from this study ultimately suggested that an individual's attachment representation is associated with emotion regulation.

Insecure attachment styles frequently lead to enduring problems in social relationships, which may be partly due to how individuals with BPD relate to others (Beeney et al., 2015). Beeney et al. (2015) conducted a quantitative, cross-sectional study to determine how impairments in social cognition such as maladaptive mental representations of self, others, and self in relation to others were connected to attachment insecurity of those diagnosed with BPD. Experimental indicators of mentalization, self-other boundaries, and identity diffusion were tested as mediators between attachment style and personality disorder symptoms. In a cross-sectional structural equation model, mentalization and self-other boundaries facilitated the relationship between attachment anxiety and BPD. The authors' findings support theories that insecure attachment is linked with challenges in social cognition and that a distinctive pattern of impairment typifies BPD. Furthermore, attachment styles for mothers with BPD showed more insecure preoccupied and unresolved attachment patterns than healthy mothers (Macfie, Swan, Fitzpatrick, Watkins, & Rivas, 2014). Therefore, a BPD diagnosis in African American mothers may explain the multiplex factors that shape the intergenerational transference of disorganized attachment patterns.

## Literature on Personality Disorders

According to the American Psychiatric Association (2015), mental disorders are categorized as behavioral or psychological conditions or patterns of individual behavior that are associated with distress, diminished function, considerably heightened risk of depression, death, discomfort, loss of liberty, or debility. The term mental disorder commonly refers to health illnesses that are characterized by alterations in reasoning, temperament, and/or conduct (Weir, 2012). There are currently 10 recognized personality disorders that are classified into three clusters (Cluster A, Cluster B, and Cluster C) based on descriptive likenesses, according to the *DSM-5* (American Psychiatric Association, 2013). As reported in the *DSM-5*, a personality disorder is described as a continuing pattern of inner experiences and behavior that significantly deviates from the expectations of an individual's culture (American Psychiatric Association, 2013). Common signs of a personality disorder include extreme behavior, rigidity, anger, mood swings, avoiding people or things, unstable interpersonal relationships, obsessive behavior, isolating one's self, and the inability to control one's emotions or behavior (Franklin, 2015). The *DMS-5* further describes a personality disorder as pervasive, uncompromising, condition that leads to impairment and distress. Individuals who suffer from personality disorders can display a variety of symptoms that range from just a few symptoms to exhibiting all relative symptoms (Clement et al., 2015; Franklin, 2015).

A person with a personality disorder can be high functioning or low functioning (Franklin, 2015). According to Franklin (2015), high functioning individuals tend to be

aware of their disorders and they may be able to maintain normal personal, professional, and/or public profiles. Low functioning individuals may be unable to hide their personality disorders from others (Franklin, 2015). Individuals who have a Cluster B personality disorder particularly have a difficult time sustaining healthy relationship attachments (Turner, Sebastian, & Tüscher, 2017).

**Prevalence of Personality Disorders**

Approximately one in five adults in the U.S. (46.6 million U.S. adults or 18.9% of U.S. adults) live with a mental illness such as a diagnosis of a personality disorder (Mental Health America, 2017; National Alliance on Mental Health, 2017). What is more, an estimated 15–23% of children may live in homes where a parent has a mental illness, with parental mental illness predisposing children to later mental disorders (Isobel et al., 2019). Results from the 2016 Adult Psychiatric Morbidity Survey revealed the following self-reported rates of mental illness among those who responded to the survey: one in six adults (17%), one in five women (20.7%), and one in eight men (13.2%) (Gullard, 2016). Moreover, the research findings showed that the prevalence of mental health problems had been growing since the survey was first conducted in 1993.

According to Quirk and colleagues (2016), the general prevalence reported for any personality disorder has been found to be at 13.4%. Volkert, Gablonski, and Rabung (2018) conducted a systematic review and meta-analysis database search for studies that used standardized diagnostics (DSM-IV/-5, ICD-10) to report prevalence rates of personality disorders in community populations in Western countries. Prevalence rates were extracted and grouped by random-effects models. Meta-regression and sensitivity

analyses were performed and publication bias was reviewed. The final sample included ten studies, with a total of 113,998 individuals. Their impression was that prevalence rates were fairly high for any personality disorder (12.16%; 95% CI, 8.01-17.02%) and similarly high for DSM Clusters A, B and C, between 5.53 (95% CI, 3.20-8.43%) and 7.23% (95% CI, 2.37-14.42%).

Personality disorders typically have their onset in adolescence or in early adulthood; however symptoms become more manageable over time, according to the *DSM-5* (American Psychiatric Association, 2013). What is more, Quirk et al. (2016) explained that individuals who were separated or divorced had the highest rates of personality disorders. Certain personality disorders such as paranoid, schizoid, and schizotypal (Cluster A) are more commonly diagnosed in men and are most prevalent in younger men, while other personality disorders such as histrionic, narcissistic, antisocial and borderline personality disorders (Cluster B) are more frequently diagnosed in women (APA, 2013; Quirk et al., 2016).

Findings from preceding research has revealed that women are significantly more likely to be diagnosed with BPD than men, with women making up 75% of the diagnosed cases of BPD in the United States (American Psychiatric Association, 2013; Pedneault & Gans, 2018). While statistical data have revealed that approximately 1.6% of adults in the United States aged 18 years and older harbor this Cluster B disorder, current research seems to indicate that the percentage of BPD prevalence may be as high as 5.9% in the United States, with an estimated 9% of U.S. adults having at least one personality

disorder (American Psychiatric Association, 2015; National Alliance on Mental Illness, 2017).

The prevalence of mental health problems differs by ethnic group for women, but not for men; White women are at a 15.6% prevalence rate, while Black women are at a 29.3% rate (McManus, Bebbington, Jenkins, & Brugha, 2016). What is more, women are reported to be more likely to have mental health disturbances than men (Gulland, 2016). McManus et al. (2016) explored the association between ethnicity, mental health problems, and socioeconomic status (SES). The authors found that people from Black ethnic backgrounds in the United States tend to have a higher rate of psychosis compared to Whites. Moreover, African Americans are reported to be 20% more likely to suffer from serious mental health problems than the general United States population, and are often over-diagnosed with schizophrenia (Gershon & Thompson, 2018; National Alliance on Mental Illness, 2016).

**Borderline Personality Disorder Defined**

Borderline personality disorder was first recognized in the 1960s (Gunderson, 2009; Stoffers-Winterling et al., 2018). According to the *DSM-5*, BPD was Eventually acknowledged as an official diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders* in 1980 (American Psychiatric Association, 2013). Originally believed that those who demonstrated borderline characteristics were at the "border" of psychosis and neurosis, (Stoffers-Winterling et al., 2018), BPD has since been defined as an Axis II Cluster B personality disorder marked by pervasive affective and behavioral patterns such as emotional instability, chronic feelings of emptiness, inappropriate intense bouts

of anger and momentary stress-related paranoid ideation, poor self-image, impulsivity, and chaotic interpersonal relationships as well as severe dissociative symptoms (American Psychiatric Association, 2013).

According to the American Psychiatric Association (2017), symptoms of BPD begin manifesting in early adulthood. BPD may be also referred to as emotional instability disorder, emotion-impulse regulation disorder, or emotionally unstable personality disorder, and may be synonymously used with emotional dysregulation disorder (Jani et al., 2016; Ridings & Lutz-Zois, 2014; Psychological Care and Healing Treatment Center, 2017). BPD is described as a mental disorder that manifests as mental, behavioral, and emotional dysregulation (National Alliance on Mental Illness, 2017). According to findings from various research studies on BPD, individual trauma variables such as physical abuse, emotional abuse, sexual abuse, or witnessing violence have been found to be contributing factors to the disorder's onset (Amad, Ramoz, Peyre, Thomas, & Gorwood, 2019; Dye, 2018; Penfold, Denis & Mazhar, 2016). Furthermore, researchers have found etiologic factors such as trauma in childhood, genetic substrate (weak temperament), a triggering event or series of events (i.e., severe life stressors) as well as parental psychopathology to be unequivocally linked to the development of BPD (Penfold, Denis & Mazhar, 2016). Diagnostic criteria for the disorder according to the *DSM-5* include

- frantic efforts to avoid real or imagined abandonment,
- a pattern of unstable and chaotic interpersonal relationships characterized by extremes between idealization and devaluation (also known as "splitting"),

- identity disturbance marked by unstable self-image,
- impulsive behavior,
- recurrent self-harming behavior,
- emotional instability,
- chronic feelings of emptiness,
- inappropriate intense anger, and
- momentary, stress-related paranoid ideation or acute dissociative symptoms (American Psychiatric Association, 2013).

BPD typically co-occurs with a litany of disorders, which include but are not limited to narcissistic personality disorder (NPD), intermittent explosive disorder (IED), depression, anxiety, post-traumatic stress disorder (PTSD), eating disorders, and substance abuse disorder (Beatson & Rao, 2013; Biskin & Paris, 2013; Perez-Rodriguez et al, 2012; Weinberg & Ronningstam, 2020; Zimmerman et al., 2019). Researchers have suggested that while BPD should be considered as a primary diagnosis, clinical evidence suggests that symptoms of other conditions that are comorbid with BPD may lead psychiatric health professionals to entirely miss the diagnosis of a personality disorder. According to Harley, Eisner, Prairie, and Jacobo (2016), BPD has significant symptomatic overlap with schizophrenia, impulsive disorders, dissociative disorders, and identity disorders. Furthermore, BPD has also been found to share similar clinical features with bipolar disorders, which are oftentimes confused with each other (Morgan & Zimmerman, 2015; Paris & Black, 2015).

BPD has been classified as a mental disorder that plagues sufferers with intense affective distress and a pattern of unstable relationships (Bilek et al., 2017; Romaniuk, Pope, Nicol, Steele, & Hall 2016). As a result, individuals with BPD have been known to undermine and destroy mutually beneficial relationships (Miano, Fertuck, Roepke, & Dziobek, 2017). People with BPD frequently engage in behaviors that may result in negative consequences, including but not limited to binge eating, using substances, self-injuring, impulsiveness, volatility, fighting, yelling, verbal aggression and intense emotional reactions (Selby & Joiner, 2013; Westbrook & Berenbaum, 2017). Theories of BPD propose that relational problems for people with BPD can act as triggers for negative affect and result in emotion dysregulation (Hepp, Carpenter, Niedtfeld, Brown, & Trull, 2017). Hepp et al. (2017) conducted a quantitative study that examined the associations between temporary negative affect (hostility, sadness, fear) and interpersonal problems (rejection, disagreement) in a sample of 80 BPD and 51 depressed outpatients at six time points over 28 days. Data were analyzed using multivariate multilevel modeling to separate momentary-, day-, and person-level effects. Study results showed a reciprocally reinforcing relationship between disagreement and hostility, rejection and hostility, and rejection and sadness in both groups at the transitory and day level. The mutual reinforcement between hostility and rejection/disagreement was considerably stronger in the BPD group.

Relationships burdened with conflict are a characteristic of close connections for those with BPD (Lazarus et al., 2019). Individuals with BPD have been found to gain more stability in their relationships in their 30s and 40s, while growing evidence suggests

that BPD can still more benefit from early intervention (Akça, et al., 2020; American Psychiatric Association, 2013). Nevertheless, general inclinations toward intense affective control, impulsiveness, and carelessness within relationships have been found to be typically lifelong for those people with BPD, with the lifetime prevalence of BPD at approximately one and three percent (American Psychiatric Association, 2013; Nia et al., 2018).

A 2017 linear regression analysis conducted by Vossen, Coolidge, Segal, and Muehlenkamp revealed that two out of the three "Dark Triad" malevolent personality traits that were psychopathy (characterized by insensitivity, unemotional, antisocial behavior, impulsivity, and selfishness,) and Machiavellianism (characterized as manipulation, amorality, lack of emotional sensitivity, exploitative of others, and self-centeredness) were significant predictors of BPD, with Machiavellianism being the stronger predictor. Individuals who are high in Dark Triad traits are most likely to have dismissive or avoidant attachment, suggesting that interpersonal relationships with others are less important than material and extrinsic achievements (Curtis & Jones, 2020). The complementary "Vulnerable" Dark Triad (VDT) identifies three relationship-driven personality traits: secondary psychopathy, vulnerable narcissism, and borderline personality disorder (Curtis & Jones, 2020). Individuals high in VDT traits seek interpersonal relationships with others and have motives and attachment goals that involve intimacy and closeness (Curtis & Jones, 2020). However, the inclusion of BPD within this trio of malign personality traits stems from the presence of low sociability, high neuroticism, and elements of impetuousness as well as interpersonal difficulties

associated with those with the disorder (Curtis & Jones, 2020). According to Lazarus, Cheavens, Festa, and Rosenthal (2014) the low quality of intimate relationships among those with BPD may be partially attributed to (a) the BPD individual's low capability to understand their own mental health state and emotions as well as that of others; (b) the individual with BPD's cognitive responsiveness; and (c) high reports of personal distress from the individual with BPD; and (d) the individual with BPD's empathetic ability within interpersonal relationships.

**Genetics and BPD**

As an understanding of the generational impact of BPD continues to emerge, Florange and Herpertz (2019) explained that parenting stress, faulty behavioral patterns, and emotion dysregulation experienced demonstrated by parents with BPD towards their children impinge on the development of healthy parent-child relationships, and expose offspring to a greater risk developing BPD. Emotion dysregulation (e.g., impulsivity, aggression) is a core characteristic present in people with BPD, and is often attributed to an imbalance in frontolimbic brain network functioning (Soloff et al., 2017; Soloff, Abraham, Ramaseshan Burgess, and Diwadkar, 2017). According to Lockhart, Davis, & Miller (2017), BPD has been recognized as a maladaptation disorder due to its evidential association to environmental exposure; however, several recent research studies shown a possible genetic component to BPD. Epigenetic mechanisms have been described in numerous mental disorders including mood disorders, anxiety disorders and schizophrenia (Gescher et al., 2018). Gescher et al. conducted a literature review on current data that examined the connection between distinctive epigenetic mechanisms and

personality disorders. Using PRISMA guidelines to perform a systematic literature review of 345 publications, the authors found nine studies on borderline personality disorder and gene methylation pattern. Results of these studies showed significant links between personality disorder and gene expression, and suggested evidence for epigenetic processes in the development of personality traits and personality disorders. Furthermore, BPD was found to repeatedly affect an individual's neurofunctional genes.

According to Streit et al. (2020), twin and family studies indicate that genetic factors contribute to BPD and borderline personality features, and that these are partially shared with the factors influencing personality traits as well as other psychiatric disorders. BPD has been categorized as a heterogeneous clinical phenotype that develops as a result of interactions among genetic, biological, neurodevelopmental, and psychosocial factors (Ruocco et al., 2019). Predicated upon the aforementioned understanding, Ruocco et al. (2019) conducted an in-depth study that evaluated the familial aggregation of key clinical, personality, and neurodevelopmental phenotypes in probands with BPD ($n$ = 103), first-degree biological relatives ($n$ = 74; 43% without a history of psychiatric disorder), and non-psychiatric controls ($n$ = 99). Study participants were evaluated according to DSM-IV psychiatric diagnoses, symptom dimensions of emotion dysregulation and impulsivity, 'big five' personality traits (openness, conscientiousness, extraversion, agreeableness, and neuroticism), and neurodevelopmental characteristics, as part of a larger family study on neurocognitive, biological, and genetic markers in BPD. The researchers found evidence of familial aggregation for specific dimensions of impulsivity and emotion dysregulation, and the

'big five' traits neuroticism and conscientiousness. Both probands and relatives reported an elevated neurodevelopmental history of attentional and behavioral difficulties. The authors concluded that study results support the validity of negative affectivity and impulse-spectrum phenotypes associated with BPD and the risk that the disorder poses to families.

Amad et al. (2019) conducted a quantitative study that genotyped five *FKBP5* (a co-chaperone of the glucocorticoid receptor) SNPs (rs3800373, rs9296158, rs737054, rs1360780, rs9470080) in a sample of 101 distinct Caucasian patients with BPD and 111 ethnically matched healthy controls. The association between *FKBP5* polymorphisms and childhood trauma was also evaluated. Results for the analysis revealed that all *FKBP5* polymorphisms genotyped showed substantial associations with BPD. A key effect of rs9470080 ($p = 0.01$) and gene x environment (physical abuse) interaction ($p = 0.01$) was found. A gene x environment (emotional abuse) interaction was also found for rs3800373 ($p = 0.03$). The authors concluded that BPD is associated with *FKBP5* polymorphisms, while various forms of childhood abuse may moderate the effect between *FKBP5* SNPs and this disorder.

**BPD: African American Women and Other Racial Groups**

According to Gershon and Thompson (2018), African Americans with mood disorders are more likely to stay constantly ill than European Americans. Moreover, Burnett-Zeigler, Satyshur, Hong, Wisner, and Moskowitz (2019) explained that major depressive disorder has a high prevalence among African American women. Yet, there is relatively less research on the relationship between emotion regulation and

psychopathology among Black individuals compared to White and Asian individuals (Haliczer et al., 2019). In spite of the comparatively limited research on BPD across racial groups, emerging data suggest that the prevalence of BPD varies across racial and ethnic groups in the U.S. (De Genna & Feske, 2013; Haliczer et al., 2019). Findings from Chavira et al. (2003) indicate that African Americans may present with different patterns of personality pathology. Evidence also suggests that BPD occurs at comparatively higher rates among Black study participants than the population average (Tomko et al., 2014). Newhill, Eack, and Conner (2009) conducted a study on the experience of BPD among ethnic minorities and how this varies from Whites. Affective and behavioral symptoms of BPD were studied in 17 African Americans and 27 White Americans with the disorder. Results suggested that African Americans experience greater emotional intensity and emotional dysregulation, fewer self-harming behaviors, and more thoughts of interpersonal aggression than Whites. These findings further indicated that not only is BPD not a disorder exclusive to White females, but that the experience of the disorder may differ substantially across races.

According to Selby and Joiner (2008), because of vital psychological and socio-cultural differences that are associated with different ethnic groups, some symptoms of BPD may be more tolerated in one ethnic group, whereas other symptoms may be viewed as more abnormal. For example, cultural values may mediate the way that individuals regulate their emotions, with cultures encouraging or discouraging different emotional responses according to differing circumstances (Selby & Joiner, 2008). Selby and Joiner (2008) examine differences in the factor structure of borderline personality disorder

symptoms among different ethnic groups. The authors obtained information regarding ethnic identity and endorsement of borderline personality disorder criteria for an ethnically diverse community sample of 1140 young adult subjects: 28% (N = 322) non-Hispanic white (Caucasian) subjects, 46% (N = 525) Hispanic subjects and 26% (N = 293) African American subjects. An exploratory factor analysis was conducted to examine differences between Caucasian, Hispanic and African American groups. A principal-components factor analysis (PCA) with Varimax rotation for each ethnic group revealed a moderately generalizable four-factor structure: affective dysregulation, cognitive disturbance, disturbed relatedness and behavioral dysregulation. The results of this study indicate African Americans have been found to have more difficulties controlling impulses contributed to the affective dysregulation factor than Whites and Hispanics with BPD, which Selby and Joiner (2008) explained may be because African American individuals may respond to upsetting emotions with non-suicidal impulsive behavior – perhaps to regulate affect.

De Genna and Feske (2013) conducted a 2013 cross-sectional study that aimed to distinguish differences between white and African-American female outpatients with a DSM-IV diagnosis of BPD. Eighty-three women with BPD participated in this study ($n$ = 41 white and $n$ = 42 African-American), where a series of structured interviews and questionnaires were used to assess Axis I and II disorders and capture internalizing and externalizing symptoms. Results from the study revealed that White women with BPD reported more acute internalizing symptoms, whereas the African-American women reported more severe externalizing symptoms. De Genne and Feske concluded that

African-American women with BPD may demonstrate more severe symptoms of lack of anger control and fewer suicidal behaviors than those of white women with BPD. The authors explained that these findings raise the possibility that African American women are misdiagnosed and receive treatments that are not optimal for BPD. Similarly, Jani et al. (2016) explained that while Black individuals are less likely to receive a BPD diagnosis compared to their White counterparts, Black individuals who have BPD experience greater affective intensity, emotion dysregulation and more interpersonal aggression than White individuals with BPD. Researchers have suggested that African American with BPD symptoms may benefit from treatment of cognitive symptoms, as well as explore the effects of socio-cultural aspects of ethnicity on those symptoms (Selby & Joiner, 2008). Nevertheless, researchers have considered the limited range of verified outcomes in research on differences in psychiatric disorders between Black and White individuals (Erving, Thomas, & Frazier, 2018), and have maintained that BPD remains racially understudied in psychiatric literature due to the disorder's cultural perception as a "White" illness (Cahn, 2014; McCloud, 2013; Newhill, Eack, & Conner, 2009).

**Mothers and BPD**

Disordered self-identity, mood instability, and chaotic interpersonal relationships, are key dimensions of BPD (Jani et al., 2016). As a result, parents who have BPD can be abusive, physically and emotionally negligent, and can demonstrate affectionless psychopathy towards their children (Infurna et al., 2016). Ntshingila, Poggenpoel, Myburgh, and Temane (2016) conducted a qualitative inquiry using a explorative,

descriptive and contextual study design in order to explore and describe the experiences of women living with BPD. Data was gathered by in-depth phenomenological interviews from eight participants ($n$ = 2 white and $n$ = 6 African-American) living with BPD. Findings from the study showed that participants experienced persistent feelings of emptiness within themselves. Participants also presented with a pattern of chaotic interpersonal relationships, mental health problems, emotional disturbance, loneliness and cultural stigma. Data from the study revealed that all participants desired for an emotional escape and better mental health.

Maternal mental illness in particular could adversely affect an entire family (Leonard et al., 2018). Maternal BPD symptoms have been linked to poorer parenting; as research evidence indicates that mothering can be overwhelming and at times be an unnerving undertaking for a woman with BPD (Lawson, 2016; Zalewski et al., 2014). Mothers who have BPD typically display temperament traits such as capriciousness, explosive emotional outbursts, and ferocity when expressing distressing emotions (Lawson, 2016). Numerous study findings showed a direct link between parental BPD and an increased risk of child maltreatment (Dittrich et al., 2018; Hiraoka et al., 2016; Laulik, Allam, & Browne, 2016). According to Florange and Herpertz (2019), poor behavior demonstrated by mothers with BPD could impede the formation of a healthy parent-child relationship and disturb offspring emotional development. Furthermore, offspring have been found to be at an increased risk of developing BPD, with parental emotional instability playing a considerable mediating role (Florange & Herpertz, 2019). Kluczniok et al. (2018) conducted a quantitative study that investigated the effect that co-

occurring maternal mental disorders (such as maternal BPD) had on parenting behavior. Interactions of 178 mother-child dyads (children aged between 5 and 12 years old) were assessed during a play situation using the Emotional Availability Scales. Results from the study showed that mothers with BPD displayed increased hostility during mother-child interactions. Additionally, maternal hostility was found to be a mediator between maternal BPD and various child psychiatric disorders such as externalizing and internalizing disorders.

Petfield et al. (2015) conducted a literature review to explore the challenges of parenting faced by mothers with BPD and the impact that those challenges had their offspring. The authors reviewed 17 studies retrieved from PsycINFO and MEDLINE. Findings from the review revealed that mothers with BPD often presented with comorbid disorders such as PTSD, major depression, dysthymia (also known as persistent depressive disorder) and psychoactive substance abuse. Petfield et al. (2015) also found that mothers with BPD demonstrate low levels of mind-mindedness, and create family environments that are typically hostile and low in unity.

**Outcomes for Offspring of Mothers With BPD**

Borderline personality disorder is a distressing mental health disorder that affects individuals diagnosed with the condition as well as their relationships with family, friends, and romantic partners (O'Donohue & Lilienfeld, 2013). Living with a loved one who has BPD can cause emotional strain, and could lead to emotional distress including anxiety, anger, self-reproach, frustration, desolation, and despondency in family members of those with BPD (Fossati & Somma, 2018). Family members of people with BPD have

been found to experience harmful interpersonal consequences as a result of their relative's illness (Miller & Skerven, 2017). According to Noonan (2017), offspring of parents with mental illness/mood disorders such as BPD can find encounters with their parents to be exhausting. Noonan went on to explain that dealing with the daily distortions in thinking and behavior demonstrated by parents with BPD can disrupt the children's daily patterns and family routines.

People with BPD can leave those who they are close to feeling confused and overwhelmed due to displays of splitting behaviors associated with devaluation and idealization (Fertuck, Fischer, & Beeney, 2018). Splitting behaviors can overlap behavioral standards associated with the Karpman Drama Triangle of Codependency. Karpman (1968) formulated this social interaction model to diagram conflict-laden relationship transactions. Children who were raised by parents with BPD have been found to be familiar with the codependency drama triangle (Liotti & Farina, 2016). The three dysfunctional and destructive social roles within this drama triangle include the rescuer, the persecutor, and the victim (Karpman, 1968; Liotti & Farina, 2016; Lockhart et al., 2017). Furthermore, researchers explained that individuals with BPD typically play out each dysfunctional role of the triangle (Pearce & Critchlow, 2019).

Bartsch et al. (2015) conducted a qualitative study to explore the opinions of mental health clinicians regarding the impact that parental BPD has on offspring. The researchers gathered data from the opinions of 64 clinicians. Thematic analysis of the 64 clinicians' responses revealed that children of parents with BPD exhibited the following five characteristics: behavioral problems, emotional dysregulation, interpersonal

difficulties, cognitive dysregulation, and ipseity disturbance (self-disorder) (Bartsch et al., 2015). Evidence suggests that children with parents who have BPD can grow up to be egocentric and demonstrate affectionless psychopathy towards others (Gibson, 2015; Kaufman et al., 2017; Petfield et al., 2015). Moreover, unstable emotional temperament and inconsistency in parents with BPD have been found to limit the development of reactive emotions, objectivity, and emotional intimacy in offspring, which can make it difficult for them in adulthood to form healthy interpersonal relationships (Cullen et al., 2014; Gibson, 2015; Lawson. 2016). Lawson (2016) explained that children who are raised in environments where the primary caregiver is not emotionally attuned may be more likely to encounter constant abuse, remain at risk for acquiring low self-esteem, and may be more likely to develop BPD in adulthood.

Adult offspring of a parent with mental illness have described having a strained relationship with their parent (Patrick, Reupert, & McLean, 2019). Compared to adults in the general population, researchers have found that adults who were raised by parents with mental illness had lower self-esteem, experience uncertainty within their interpersonal relationships, and have a difficult time forming intimate connections as well as remain at an increased risk for psychosocial problems (Murphy et al., 2018; Patrick et al., 2019). A parent's diagnosis of BPD can negatively impact and disrupt the development of secure attachments in their offspring, and ultimately impair their ability to form healthy interpersonal relationships (Bateman & Fonagy, 2018; Petfield et al., 2015; Stepp et al., 2012). Due to negative experiences that adult offspring have had with their parents who have BPD, such individuals have been found to hold distorted views of

what defines a stable relationship, ultimately discouraging them from forming close relationships (Gibson, 2015; Noon, 2017). Because of the unstable emotional and behavioral encounters that adult offspring have had with their parents who have emotion regulation difficulties (like parents with BPD), Gibson (2015) explained that adult offspring may ultimately perceive close relationships as burdening or confining. Moreover, a parent's emotional neglect or rejection towards their child due to emotional dysfunction could foster an insecure attachment style, low self-confidence, hostile adult relationships, and lead to increased risk of repeating frustrating relationship patterns in children (Gibson, 2015).

Insecure attachments could predispose children to emotion dysregulation, poor social skills and problematic relationships (Infurna et al., 2016). What is more, adults can project ingrained models of attachment onto new partners and treat new partners in the similar way that they related to past attachment figures (Mikulincer & Shaver, 2016). Adult offspring of parents with psychological and emotional challenges may form insecure attachment styles, have a challenging time being intimate with others, and develop concerns about their ability to form and maintain close relationships in adulthood (Gibson, 2015; Streep, 2017). Research evidence suggests that a parent's diagnosis of BPD can disrupt the development of secure attachments in their offspring, and ultimately impair their ability to form healthy interpersonal relationships (Bateman & Fonagy, 2018; Crowell, 2016; Petfield et al., 2015). For instance, instead of properly understanding and processing their partner's emotions, the adult offspring might become preoccupied with interpreting and misinterpreting feelings, scenarios, circumstances, and even their

security within the relationship (Gibson, 2015; Noon, 2017; Petfield et al., 2015). What is more, parental invalidation demonstrated by parents with BPD as well as attachment disorganization have been theorized to play an etiological role in offspring psychopathology (Lyons-Ruth, Brumariu, Bureau, Hennighausen, & Holmes, 2015).

Research on the pathogenesis of BPD as well as psychotherapy for BPD produced evidence suggesting that attachment disorganization contributes to borderline psychopathology ((Liotti, 2013). Furthermore, researchers posit that the quality of primary relationships is an important factor in child development because it can generally influence the development of an individual's personality (Moscoso et al., 2018). Children of mothers who have BPD are at an increased risk for demonstrating attention difficulties, hostile behavior, low self-esteem, affectionless psychopathy, depression, anxiety, and BPD itself (Campbell, 2020; Cullen et al., 2014; Murphy et al., 2018). Moreover, evidence suggests that a mother with BPD can negatively impact their child's formation of a secure emotional base, leaving the child without a healthy example of conflict resolution practices, emotional regulation, and interpersonal functioning (Kaufman et al., 2017; Petfield et al., 2015). Eyden, Winsper, Wolke, Broome, and MacCallum (2016) conducted a systematic review of parenting and outcomes experienced by offspring of mothers with BPD. The authors found that children with parents diagnosed with BPD experienced negative outcomes such as unconscious assimilation of depressive behaviors, insecure attachment styles, emotion dysregulation and symptoms of BPD.

According to Petfield et al. (2015), children who have mothers with BPD have been found to have poorer overall mental health in comparison to children of both psychologically healthy mothers and mothers with other personality disorders like bipolar disorders. Findings from Petfield et al.'s literature review also revealed that insecure-resistant attachment styles were found in children as early as infancy who had mothers with symptoms of BPD. Older children were found to display a variety of cognitive and behavioral risk factors (e.g., harm avoidance, dysfunctional attitudes and responses), and have poorer relationships with their mothers (Petfield et al., 2015). Moreover, Petfield et al. explained that maternal BPD symptoms were found to adversely affect older children's ability to form close relationships. The authors concluded that findings from this qualitative review support the interpretation that children of mothers with BPD are predisposed to disrupted physiological, emotional, social development, and insecure attachment styles.

According o Sutherland, Baker, and Prince (2019), families and carers of relatives with BPD experience high levels of burden. Kirtley, Chiocchi, Cole and Sampson (2019) conducted a study that aimed to explore whether perceived stigma, threat of strong emotions, and expressed emotion (EE) within family environments where a relative has BPD predicted carer burden. Ninety-eight carers completed a questionnaire-based study. Fifty-seven carers of people who meet the diagnostic criteria for BPD were compared to 41 carers of individuals with other mental health problems. Results from the Kirtley et al. study showed that carers of those who met the diagnosis for BPD experienced higher levels of carer burden, stigma, EE, emotional over involvement (EOI), criticism (CC),

and perceived threat of strong emotions than carers of individuals with other mental health difficulties.

According to Bailey and Grenyer (2015), people who have loved ones with BPD can experience home environments high in expressed emotion, criticism, and emotional overinvolvement. The researchers conducted a study to explore the relationship between expressed emotion, carer burden and carer wellbeing for those who have a relative with borderline personality disorder. Two hundred and eighty carers of a relative with family member with BPD were administered the McLean Screening Instrument for BPD – Carer Version, The Family Questionnaire, Burden Assessment Scale and Mental Health Inventory. Results from this study showed that carers reported family environments significant in expressed emotion, particularly criticism (82.9% of carers) and emotional overinvolvement (69.6%). High emotional overinvolvement was linked to higher burden and mental health problems. Bailey and Grenyer concluded that high levels of criticism and emotional overinvolvement in family environments indicate a dynamic involving high conflict, anxious concern, overprotection and emotional closeness. Findings further suggest that carers may benefit from intervention and support options considering the chaotic interpersonal dynamic, burden and compromised carer wellbeing.

Loved ones of individuals with BPD can feel confused, frustrated and angry (Kreisman & Kreger, 2018). According to Allen (2018), because children of parents who have BPD spend an ample amount of time and effort pacifying their emotionally unstable parents, they are likely to repeat or exhibit dysfunctional relationship patterns. Children who grow up with a parent with an emotional dysfunctional disorder may mature into

adulthood expecting that they will receive the same disregard within other interpersonal relationships (Streep, 2017). Consequently, Streep (2017) explained that offspring may form relationships in adulthood with the guiding belief that intimacy within meaningful relationships is unachievable. Metz and Jungbauer (2019) conducted a qualitative study on the perpetual impact of parental mental illness on adult offspring's biographies, personalities, and social relationships. The life course perspective was used to guide the study, and enabled the authors to examine participants' experiences in childhood, adolescence, and adulthood. Adult offspring ($n$ = 18) who experienced childhood parental mental illness participated in an in-depth interview study reported on a number of intrapersonal difficulties that they perceived to be a result of their disappointing childhood experiences. Metz and Jungbauer found that adult offspring often felt adversely influenced and hindered regarding their health, identity, behavior and social relationships as well as in their daily life experiences.

Widom, Czaja, Kozakowski, and Chauhan (2018) conducted a quantitative study that aimed to determine whether: a) childhood physical abuse and neglect lead to different attachment styles in adulthood, b) adult attachment styles predict subsequent mental and physical health outcomes, and c) adult attachment styles mediate the relationship between childhood physical abuse and neglect and mental and physical health outcomes. Results from the study revealed that individuals who had histories of childhood physical abuse had more anxious attachment styles in adulthood, whereas childhood neglect predicted avoidant attachment (Widom et al., 2018). Furthermore, path analyses revealed that anxious attachment styles in adulthood partially explained the

relationship between childhood neglect, physical abuse, depression and anxiety, and self-esteem. The authors concluded that childhood neglect and physical abuse have long-term effects on adult attachment styles. Consequently, research evidence supports the understanding that factors such as maladaptive parenting, rejecting parenting styles, attachment disorganization and early unstable patterns of interaction remain as strong predictors of emotional vulnerability as well as BPD symptoms (Moacoso et al., 2018).

Küng et al. (2019) conducted a study that investigated the prevalence of psychiatric diagnoses presented by offspring of patients with bipolar disorder or borderline personality disorder**.** The researchers recruited 22 offspring of patients with BPD, 21 offspring of patients with bipolar disorder, and 23 control subjects. Descriptive and analytic statistics were performed, and univariate comparisons between groups were conducted as well as a one-way analysis of variance. Finding suggested that BPD offspring present a higher rate of psychiatric disorders compared to offspring of bipolar patients. A study conducted by Kerr, Dalrymple, Chelminski, and Zimmerman (2018) explored if BPD features in depressed parents would be associated with increased morbid risk of offspring major depressive disorder and substance use disorders (SUDs). Participants included 912 psychiatric outpatients with a main diagnosis of MDD. Semi-structured interviews verified diagnoses of parents and their 2,011 reported offspring. The authors compared the offspring's morbid risk of MDD and SUDs based on whether their parents had BPD, ≥1 BPD criteria, as well as by each criterion. Offspring of parents with ≥1 BPD criteria had higher morbid risk of MDD and SUDs. Results suggested that BPD features present added risk to offspring beyond that of parental depression alone.

Researchers maintain that an insufficient amount of support is typically offered to family members who attempt to support their relatives diagnosed with borderline personality disorder (Kay, Poggenpoel, Myburgh, & Downing, 2018). Furthermore, family members of relatives with BPD have been found to often experience stress, depression, grief and isolation as a result of this lack of support (Kay et al., 2018). Kay and colleagues conducted a 2018 qualitative study that explored the accounts of family members who have a relative diagnosed with BPD in an effort to describe their experiences. Through an exploratory, descriptive and contextual study design, the researchers used purposive sample of family members aged between 24 and 74 years old. Data was gathered by conducting eight in-depth, phenomenological interviews. Results from the study presented four themes. One theme that was identified included family members describing their relative diagnosed with BPD as experiencing emotional, behavioral, interpersonal and self-dysregulation. Family members expressed negative feelings towards their relatives and experienced social humiliation, financial strain and marital discord. Another identified theme was that family members experienced a desire to move forward and improve their mental health. In a theme three, the data showed that family members experienced difficulties adapting and coping with their relative with the disorder. A final major theme revealed that family members pursued for harmony and integration for their families. The authors conclude that results from this study suggested that family members experienced disempowerment because they lacked knowledge about their relative's BPD.

According to Bailey and Grenyer (2015), family environments with elevated levels of expressed emotion, particularly emotional over-involvement can benefit from the clinical outcome of patients with BPD. Kreisman and Kreger (2018) explained that while individuals who have loved ones with BPD should refrain from engaging in undesirable interpersonal exchanges. Instead, people who have relatives with BPD should emphasize their support for their loved one with the disorder (Kreisman & Kreger, 2018). Relationship experiences with a loved one who has BPD can yield more predictability and preparedness for their families (Arterburn & Wise, 2017). What is more, researchers discovered that offspring of mothers who have an emotional dysregulation disorder like BPD can benefit from mentalization-based therapy (MBT), interpersonal psychotherapy (IPT), interpersonal reconstructive therapy (IRT) and dialectical behavior therapy (DBT), as these therapy intervention models have been found to address relational-trauma leading to insecure attachment, help family members cope with their own stressors, and improve various interpersonal outcomes for family members of individuals with mental illness and emotional disorders (Asen & Fonagy, 2012; Benjamin , 2018; Hughes, Golding, & Hudson, 2019; Miller & Skerven, 2017; Wilks et al., 2017). Miller and Skerven (2017) conducted a study a pilot study that evaluated the effectiveness of a family-oriented DBT program, referred to as Family Skills, in a sample of 70 participants. Participants received psychoeducation about emotion regulation disorders, and were educated on skills related to core mindfulness, validation, interpersonal effectiveness, emotion regulation, and radical acceptance. Results from the study showed that depression, hopelessness, and interpersonal sensitivity scores

significantly decreased from pre- to post educational treatment. Moreover, adult offspring have been found to desire and pursue professional support in an effort to combat any maladies they may have formed as a result of being raised by a parent with a mental illness (Metz & Jungbauer, 2019).

**African American Mother-Daughter Relationships**

The mother-daughter relationship has been recognized as a complex bond that has been purported to be vital for the healthy self-esteem and psychosocial development of girls (Baugh & Barnes 2015; Elliott et al., 2015). Researchers have found that African American mothers particularly have a significant role in shaping how their daughters perceive themselves as well as how they relate to others (Baugh & Barnes, 2015; Everet alt et al., 2016). What is more, while Hofer and Hagemeyer (2018) explained that building and maintaining interpersonal a relationship is not exclusive to any cultural background., research conducted by O'Reilly (2018) found that Black mothers have been found to significantly shape their daughters' identities.

The absence of a secure maternal attachment has been found to impact daughters in a myriad of adverse ways, including how adult daughters ultimately view, form, and interact within interpersonal relationships (Balsam & Fischer, 2014; Streep, 2017). Schmoeger, Deckert, Wagner, Sirsch, Willinger conducted a 2018 questionnaire-based study that investigated continuousness and interruption in the development of social relationships. The authors reviewed the course of social bonds and analyzed the effects of a secure intimate relationship in adulthood in conjunction with recalled maternal bonding influenced the quality of life among 207 college students. Perceptions of

maternal bonding were selected as being representative of one of the two contrasting bonding types “optimal maternal bonding” and “affectionless maternal control”, assessed by the Parental Bonding Instrument (PBI) and combined with perceptions of a sound intimate adult relationship measured by the Family Assessment Measure III Dyadic Relationships Scale (FAM-III-D). Quality of life and general health data were verified using the World Health Organization Quality of Life (WHOQOL-BREF) instrument. The authors found that students who reported “optimal maternal bonding” had intimate relationships in adulthood that were of significantly higher quality than those who recalled “affectionless maternal control”.

Family along with other features of socialization related to attachment could influence African American perceptions of what defines a successful relationship (Tinsley, 2016). Pickering, Mentes, Moon, Pieters, and Phillips (2015) conducted a qualitative study guided by grounded theory methodology to examine the perceptions of adult daughters on their mother–daughter relationships in the context of chronic conflict. The sample size included 13 adult daughters ($n$ = 13) who reported having abusive relationship with their mothers. Through semi-structured interviews, the authors found that daughters shaped their relationship and attachments with their mothers around their perceptions of injustices they experienced during their childhood. Everet alt et al. (2016) conducted a qualitative study to examine Black adult daughters’ perceptions of how their mothers impacted their self-esteem, feelings of worth, resilience, and coping skills. Seventeen Black mothers and daughters described the lessons they learned within their relationship interactions and the modes in which these lessons were relayed from the

mothers. Relationships that were perceived as "volatile", "traumatic" and "unhealthy" had very little communication, and exposed daughters to a great deal of criticism, self-deprivation and self-loathing. Findings also revealed that for some Black adult daughters, the quality of their relationship was determined by the mothers' actions as a caretaker versus a nurturer. Additionally, researchers who examined ethnic differences in attachment styles and depression among African American and European American college women found that attachment styles that encourage caution in relationships may be adaptive and normative for African American women (Cooley & Garcia, 2012).

**African Americans and Mental Health Treatment Seeking**

An estimated 14.5% of Black/African American adults suffer from a mental illness (Hollar et al., 2018; National Institute of Mental Health, 2016). Yet, African Americans remain the least likely racial group to seek out and receive mental health care services (Hollar, et al., 2018). According to Williams, George, and Printz (2020), African Americans experience more severe symptoms of mental health conditions compared to other racial groups. Moreover, Chandler (2019) explained that a number of negatives stereotypes (e.g., community opposition to mental health intervention, individual disparaging outlooks on mental health support) discourage African Americans from addressing psychological issues.

The percentage of African Americans who suffer from psychopathology and pursue treatment is approximately half that of non-Hispanic European individuals (Hollar et al., 2018: Richards, 2018). Moreover, research evidence suggests that non-Hispanic Europeans who suffer from mental illness are four to five times more likely than African

Americans to pursue ongoing treatment for mental illness. Ward, Wiltshire, Detry, and Brown (2013) conducted an exploratory, cross-sectional survey that examined African Americans' perceptions of mental illness and seeking mental health services. The authors found that African American attitudes towards mental illness and seeking mental health services revealed that stigmas related to mental illness impacted how willing they were to address mental illness.

An estimated 6.8 million Black/African American people suffer from some form of mental illness (Silas, 2019). Moreover, evidence indicates that Black women are more susceptible to numerous forms of depression than their Black male counterparts, with risk factors stemming from heightened suicidal ideations (Jones & Guy-Sheftall, 2015; Pieterse, Carter & Ray, 2013). African American women have been found to be more susceptible to mental illnesses such as major depression and PTSD (Lacey et al., 2015; National Alliance on Mental Illness, 2016). Numerous psychosocial factors such as cultural outlooks on mental health treatment seeking, limited access to culturally competent and/or minority clinicians, the SBW idealization and mental health stigmas remain as significant contributors to the increased risk for mental health distress for African American women (Hamm, 2018; Lashley, Marshall, & McLaurin-Jones 2017; Thoits, 2013; Ward et al., 2013). Stigma has been found to be perhaps the greatest barrier to mental health care for African Americans including African American women (DeFreitas, Crone, DeLeon, & Ajayi, 2018). This is partly due to harmful perceptions on mental health held by African American women, including the invulnerability of Black women to mental illness and emotional instability (Pungong, 2017).

According to the National Alliance on Mental Illness (2016), African Americans can have a difficult time identifying signs and symptoms associated with mental health conditions endures as a problematic issue for African Americans. Many African Americans have been found to believe that discussions and issues related to mental health and illness would not be appropriate to address even among family (National Alliance on Mental Illness, 2016). Failure to address mental illness within families can cause offspring of families where mental illness is prevalent to remain at an elevated risk of developing adverse psychological and behavioral health outcomes as well as perpetuate symptoms associated with mental illness (Bee et al., 2014; Plass-Christl et al., 2018; Thanhäuser, Lemmer, de Girolamo, & Christiansen, 2017). Moreover, references of "nerves" or "depression" may be cultural idioms of distress used to describe various forms of symptoms, syndromes, or disorders (DSM-5; American Psychiatric Association, 2013), and may cause many African Americans to underrate the impact of issues related to mental health in the African American community (National Alliance on Mental Illness, 2016).

According to Campbell (2020), a disconnect remains between the way in which African Americans name and describe distress and the language presented in mental health literature. The *DSM-5* defined cultural concepts of distress as "ways in which cultural groups experience, understand, and communicate pain, behavior problems, or troubling thoughts and distressing emotions". Three main types of cultural concepts may be distinguished the following concepts: (a) cultural syndromes/clusters- symptoms and attributions that are recognized among individuals in specific cultural groups, (b) cultural

idioms of distress- ways of expressing the stress that may not involve specific symptoms or syndrome, but provide collective shared ways of experiencing and talking about personal and social concerns, and (c) cultural explanations or perceived causes- labels, attributions, or features of an explanatory model that specify culturally recognize meaning or ideology for symptoms, illnesses, or distress (*DSM-5*; American Psychiatric Association, 2013).

**The strong Black woman social construct.** Historically, strength has provided as a vital culturally specific coping mechanism for the survival of Black/African American women (Nelson et al., 2016). Research evidence strongly supports the understanding that it is not uncommon for Black women to transcend gender roles assumed by their White female counterparts (Hall, 2015). However, Black women taking on such piloting roles have been found to compromise male roles, privilege and power within the Black family structure, and led to descriptions defining Black womanhood as involving work, triumph, and self-sufficiency (Hall, 2015). Thus, Hall (2015) explained that this normality has been mainly attributed to the pressure for Black women to fulfill demanding responsibilities (e.g., paid work, family tending, community support).

According to Hall (2015), Black children are characteristically groomed to be assertive, determined, and independent. Moreover, Hall explained that it is a common understanding that African American daughters are trained to assume leading family roles that require strength and self-reliance from an early age (Hall, 2015). Therefore, it is common for society to perceive the image of the African American woman as resolute, psychologically impregnable, and emotionally secure (Lewis et al., 2013). The SBW

archetype is a socially salient ideal that requires Black women to embrace the concept of remaining resilient when facing life's challenges (Baker, Buchanan, Mingo, Roker. & Brown, 2014). Baker et al. (2014) explained that this sociocultural construct demands that Black women embody stoicism and resolve, remain selfless, and display emotional, psychological and physical strength. Similarly, Stanton et al. (2017) elucidated that common media and literature depictions of African American women being innately resolute yet nurturing mothers in the face of adversity have contributed to the myth that African American women have few mental health problems.

According to Walker-Barnes (2017), the SBW social construct was the formed antithesis to three prevailing stereotypes about Black women (Jezebel, Mammy, Sapphire). Moreover, adherence to this archetype has been found to lead to an increase in poor mental and physical health results, a decline health promoting behaviors, and an elevated risk of terminating treatment early on (Walker-Barnes, 2017). Oshin and Milan (2019) explained that characteristics that are consistent with the SBW myth have been found to have higher value for Black mothers more than Latina and White mothers. According to Thoits (2013), some African-American women often view vulnerability as a contradicting image of the strength and resilience. Abrams, Maxwell, Pope and Belgrave (2014) explained that the SBW construct is a pervasive ideology in Black culture that is typified by socialized beliefs that Black women are supposed to take on numerous roles as caregivers, be stable financial providers, and sustain their families individually. However, results from recent studies have shown that Black women who embrace the SBW schema limit their quality of being by imposing undue social pressure on them to

live up to social expectations associated with the ideal (Nelson et al., 2016; West, Donovan, & Daniel, 2016). Researchers also found that the SBW social construct negatively influences Black women's ability to seek help, and predisposes them to a number of malign psychological outcomes including distress, depression and suicidal ideation (Hollingsworth et al., 2017; Nelson et al., 2016; Watson & Hunter, 2015).

Watson and Hunter (2015) conducted a quantitative study that examined whether African American women's endorsement of the SBW schema predicted increased symptoms of anxiety and depression, and whether attitudes toward professional mental health help seeking intensified psychological distress. Data was gathered from 95 participants between the ages of 18 to 65 years. Results from hierarchical regression analysis showed that support of the SBW schema was inversely and significantly correlated with two aspects of help-seeking attitudes: (a) psychological openness and (b) help seeking tendency. Findings from this study provided evidence that the SBW myth partly explained the underuse of mental health services among African American women.

Liao, Wei, & Yin (2019) explored the link between the SBW typology and poor emotional health. Through a qualitative approach, the authors examined the direct link between the SBW schema and depression, anxiety, and loneliness in an effort to explore poor health outcomes associated with the paradigm. Four intermediaries were tested, which included- maladaptive perfectionism, self-compassion, and collective coping and spiritual coping as two Africultural coping strategies for African American women- between the SBW paradigm and psychological outcomes. Two hundred and twenty-two African American women partook in an online survey, after which structural equation

modeling was performed. After controlling for age and socioeconomic status, the direct links were supported, the authors found maladaptive perfectionism to one of the supported mediator roles. For serial mediation effects, the SBW schema was first positively associated with maladaptive perfectionism, which was associated with low self-compassion and low use of collective coping, which in turn were associated with negative psychological outcomes.

Clement et al. (2015) conducted a systematic review that addressed the overarching question: What is the impact of mental health-related stigma on help-seeking for mental health problems? Sub-questions were: (a) What is the size and direction of any association between stigma and help-seeking? (b) To what extent is stigma identified as a barrier to help-seeking? (c) What processes underlie the relationship between stigma and help-seeking? (d) Are there population groups for which stigma disproportionately deters help-seeking? Five electronic databases were searched from 1980 to 2011 and references of reviews were checked. A meta-synthesis of quantitative and qualitative studies, comprising three parallel narrative syntheses and subgroup analyses, was performed. Results from this review revealed that the SBW archetype was correlated with psychological distress, foster symptoms related to distress or depression, or dissuades them from seeking mental health services. The authors concluded that this myth may be a factor in preventing African American women from seeking treatment for mental illness, which could further impair their ability to relate to their children.

## Summary

In this chapter, I provided information on British psychologist Bowlby's attachment theory and how it has been applied in research to explain human attachment behaviors (Bowlby, 1977). I also reviewed how Bartholomew and Horowitz applied attachment theory principles to their four-category model of adult attachment, and maintained that attachment patterns in childhood have enduring effects on relationship skills in adult life (Ainsworth, 1989; Bartholomew & Horowitz, 1991; Hazan & Shaver, 1994; Holmes, 2014a; Holmes, 2014b; Mesman et al., 2016; Fraley & Roisman, 2018).

Personality disorders and the DSM-5 profile and prevalence of BPD among Americans were also summarized in the review of the literature (American Psychiatric Association, 2017; Clement et al., 2015). In addition, epigenetic mechanisms of personality disorders, particularly BPD, were reviewed. I also explained how the mother-daughter relationship is a crucial part of female development, and how maternal BPD has been found to leave negative impressions on offspring, including a high risk for psychosocial and behavior problems (Etienne, 2011; Everet alt et al., 2016; Isobel et al., 2019). I then presented an overview on how offspring who have mothers with BPD are often recipients of their mother's posttraumatic pain and dysfunctional behavior, and remain susceptible to perpetuating such behaviors (Kluczniok et al., 2018; Petfield et al., 2015; Gibson, 2015; Pearson et al., 2018). I finally addressed stigmas and barriers linked to African American mental health seeking practices and how the SBW social construct possibly stood as a preemptive factor in African American female mental health treatment seeking behaviors (Abrams et al., 2014; Lewis et al., 2013).

The aim of this qualitative study is to contribute information to the greater body of mental health literature and family studies about how an Axis II Cluster B mental illness such as BPD in mothers can affect their daughters' subsequent abilities to form attachments and establish interpersonal relationships. Clinicians, therapists, mental health professionals and human services workers could promote social change by using the use the findings form this study to advocate for early interventions such as therapy and counseling in African American females. These interventionists can additionally provide psychotherapeutic treatment to help adult female offspring acquire the appropriate relationship building skills in order to form healthy attachments with others. In Chapter 3, I will discuss the research methodology for the study and the justification for the choice. The issues of trustworthiness and ethical procedures related to the chosen method will also be addressed in Chapter 3.

# Chapter 3: Research Method

## Introduction

The purpose of this qualitative study was to explore how the experiences of being raised by a mother with BPD affected adult attachments for African American women. In this chapter I will provide information on the research design of choice as well as the rationale behind the selection. My role as the researcher along with participant recruitment procedures, the methodology, description of the data collection instruments, the data analysis plan, issues pertaining to trustworthiness, and ethical practices will be addressed in this chapter. I will subsequently provide a summary at the end of the chapter.

## Research Design and Rationale

I used a qualitative transcendental phenomenological approach to conduct this study. Qualitative studies require researchers to gather data from the personal accounts of participants (Chin et al., 2012). Because my investigation involved me interviewing participants to gather their accounts of their attachment experiences with their mothers who have BPD, a qualitative approach was the most appropriate research method for this study. I sought to answer the following research question in this qualitative study: How did the experiences associated with being raised by a mother diagnosed with BPD affect subsequent adult attachments for African American women?

### Research Design

The research design for this qualitative study was transcendental phenomenological. According to Matua and Van Der Wal (2015), use of the

phenomenological approach enables a researcher to obtain descriptions of the lived experiences of an event or experience from participants. The phenomenological method also emphasizes that only those who have experienced the investigated phenomena can describe the phenomena to others (Hopkins, Regehr, & Pratt, 2017; Turley, Monro, & King, 2016). The key purpose of phenomenological research is to explore individuals' accounts of their lived experiences to present detailed descriptions of the phenomenon (Yüksel & Yıldırım, 2015). The transcendental phenomenological approach was particularly suited for this study because transcendental phenomenology allows researchers to focus less on the subjective interpretations of a phenomenon and more on participants' descriptions of their experiences (Kafle, 2013; Martirano, 2016). Transcendental phenomenology was the best approach for this study because this design allowed me as the researcher to focus on the experiences of African American women whose mothers have BPD. This approach also allowed participants to provide in-depth descriptions of their experiences with their mothers and explain how early attachment experiences with their mothers influenced or continue to influence their abilities to form meaningful relationships through adult attachments.

I considered other qualitative research methods in addition to the phenomenological approach. One such qualitative method was the case study design. According to Tumele (2015), case studies permit researchers to collect in-depth information about a single case such as an individual, an organization, an occurrence, or an entity from various sources of information. Although the case study approach can be used to investigate a phenomenon using a variety of data sources, it was not appropriate

for this investigation because this approach focuses on the progress of a single event, condition, or person over a period of time; in contrast, phenomenology focuses on numerous individuals and their experiences (Baxter & Jack, 2008; Hyett, Kenny, & Dickson-Swift, 2014; Gill, 2014; Meyer, 2015).

I additionally considered the narrative inquiry approach for the methodology for this study. Like phenomenology, narrative inquiry can be used to gather accounts of participants' inner, lived experiences of a phenomenon (Wang & Greale, 2015). However, unlike phenomenological research, the narrative inquiry approach does not intrinsically focus on the experience of the participant (Thomas, 2015). Denison (2016) explained that researchers who use narrative inquiry are characteristically more interested in the sequence of events in people's experiences as those events unfold from participants' narratives. Therefore, the narrative inquiry approach was not appropriate for this research because the aim of this study was to explore how a specific experience in participants' lives shaped their current attachment behaviors.

I also contemplated using grounded theory as the research method for this study. According to Hussein, Hirst, Salyers, and Osuji (2014), researchers use the grounded theory approach to merge concepts and categories in order to develop a theory. Both the phenomenological and grounded theory approaches focus on human phenomenon and aim to capture the essence of these experiences. However, phenomenology emphasizes the description of phenomena while grounded theory emphasizes explaining what occurrences take place during a particular experience (Gill, 2014; Hussein et al., 2014). The aim of this study was to highlight the experiences of participants rather than to

establish a theory that supports the explored phenomenon. Therefore, because grounded theory researchers aim to generate a theory using multiple data sources in order to explain a phenomenon rather than use rich description of participant experiences (Abalos, Rivera, Locsin, & Schoenhofer, 2016; Hussein et al., 2014;), the grounded theory research method was not applicable for this study's research inquiry.

I selected a qualitative method in order to gather information on how the experiences associated with being raised by a mother diagnosed with BPD affected subsequent adult attachments for African American women. According to Yin (2016), researchers use qualitative methods in order to understand occurrences within specific populations. Using a qualitative research method allowed me to examine a topic that is of significant personal interest and provided me with an opportunity to gather and present primary data on the explored phenomenon. The quantitative research approach is appropriate for examining variables pertaining to specific phenomena. However, a quantitative approach was not appropriate for this study for two reasons. First, using a quantitative method would not have allowed me to explore the perceptions and meanings that study participants had towards the study phenomenon. Rather, the quantitative method would have required that I use measurable data to present facts and uncover numerical patterns in my study (Adair et al., 2016). Secondly, quantitative research is particularly effective for gathering and presenting measurements as well as statistical, scientific, or mathematical data collected through surveys, opinion polls, and/or questionnaires or by controlling pre-established statistical data (Mertler & Reinhart, 2016; Nardi, 2018). Study objectives, data collection processes, and evidence

presentation for the quantitative research method are contrary to the aims of qualitative exploratory studies. Qualitative researchers aim to acquire and present data through participant observation, focus groups, semi/unstructured interviews, examination of texts, and conversation and discourse analysis in order to explore various phenomena (Bansal, 2018, Bryman, 2017; Kallio, Pietilä, Johnson, & Kang, 2016; Jorgensen, 2015; Palinkas et al. 2015). Because I used semistructured interviews to elicit the experiences of participants, the qualitative method was the better approach to achieve the objectives of this study.

## Role of the Researcher

As the researcher, I functioned as an impartial observer, interviewer, and investigator. In order to establish myself as the data collection instrument, I created interview questions to guide the data collection. I also took notes during the interview process. As the primary instrument in this research, I was responsible for designing the study, recruiting participants, interviewing participants, transcribing data, analyzing data, verifying data, and reporting findings of the study (see Antwi & Hamza, 2015; Brannen, 2017).

As a human services researcher and practitioner and an African American woman, I have encountered African American women who have expressed to me the personal and social impact that having a mother with BPD has had on the way in which they relate to other people. These women have disclosed to me how their experiences with this emotion dysregulation disorder currently affect their mother-daughter relationships, their relationship decisions, and their emotional expressivity. As such, I have gained slight

insight into how having a mother with an Axis II Cluster B personality disorder such as BPD can affect the way in which African American women pursue intimate relationships, how they engage with others within their emotional connections, how they exert confidence in making major life decisions, and ultimately how they perceive mental illness and mental health.

In order to minimize researcher bias in this study, I used Edmund Husserl's method of epoché, also known as bracketing. Bracketing requires that phenomenological researchers suspend their prejudices towards the topic of examination in order to accurately draw from the collected data and articulate study findings in an unbiased manner (Hall & Harvey, 2018; Tufford & Newman, 2012). Bracketing allowed me to temporarily set aside my assumptions regarding how maternal BPD influences attachment orientations in adult African American women. This method further enabled me to capture participants' descriptions of their lived experiences (see Hamill & Sinclair, 2010).

I also minimized the impact of researcher bias by employing the technique of reflexivity. According to Darawsheh (2014), researcher reflexivity is a quality control tool that requires the investigator to approach the topic of study with the understanding that personal assumptions, partialities, and biases may be present. Employing reflexivity allowed me to divulge any prejudices or personal experiences that may have shaped how I relayed participant experiences as well as the approach of the study. Additionally, reflexivity encouraged me to consider how my understanding and experiences with the phenomenon may have influence what I deemed as integral to my study. I demonstrated

reflexivity by writing in a reflexivity journal. This journal provided a space for me to document my thoughts and feelings on the data collection process on each day of researching and interviewing. In my reflexivity journal, I recorded my day-to-day emotional state, so that when it came time for me to write up my findings, I could refer back to my journal in order to reflect on myself as the researcher and provide a more effectual impartial analysis.

During the participant recruitment process, I ensured that no participant had any type of personal relationship with me through family, friends, or employment. Participants were not misled about the nature of the research and were only judged on the general nature of the investigation during the interview. Moreover, the act of collecting data did not project the impression that the researcher was "using" study participants and organizations for personal gain. In order to assure participants that their time, travel, contribution, participation and overall commitment to this study was valued and appreciated, a reasonable token of appreciation was extended to study participants. Furthermore, in order to abstain from the disadvantages of power imbalances in researcher-participant relationships, I as the researcher aimed to gain participant trust, engaged in respectful interactions, and avoided leading questions.

## Methodology

### Participant Selection Logic

The general population of individuals to whom my results might apply to is African American women whose mothers have BPD. The goal of this study was to explore how the experiences associated with being raised by a mother diagnosed with

BPD affected subsequent adult attachments for African American women. All participants met the following inclusion criteria: a) be an African American woman between 18 and 45 years of age, (b) have a mother who has BPD, and/or be an African American woman seeking support from BPD-specific online or social media support groups, (c) be from any part of the United States of America, (d) be fluent in English, and (e) be willing to consent to an audio-recorded, in-person interview or an audio-recorded telephone interview. During the initial pre-screening process, I notified interested potential study participants that I would not recruit participants who have mothers who demonstrated features of BPD without an official medical diagnosis, manifested symptoms of BPD without an official medical diagnosis, or have mothers who are believed to have undiagnosed BPD (uBPD) without an official medical diagnosis. I explained to interested potential study participants that this decision was implemented in order to ensure that all participants whose mothers have BPD have been evaluated and diagnosed by a trained medical or mental health professional.

**Sampling Procedure**

Participants for this study were recruited through purposeful sampling and snowball sampling. According to Gentles, Charles, Ploeg, and McKibbon (2015), purposeful (or purposive) sampling is a technique that entails intentionally recruiting participants who meet certain criteria for participating in a study. Therefore, purposeful sampling enabled me to recruit participants who could provide information-rich responses related to the phenomenon of interest, which were mother-daughter attachment experiences associated with maternal BPD.

Snowball sampling was also used to recruit participants for this study. This recruitment method allows the researcher to request that guaranteed participants in a study refer other individuals to the researcher who share the experience of interest in the research (Emerson, 2015). My rationale for using both sampling methods was to ensure that the opportunity to participate in the study was extended to others who share in experiences associated with the phenomenon of interest.

**Sample size.** Eleven participants partook in this study ($n$=11). The rationale for this number was based Flynn and Korcuska's (2018) recommendation that phenomenological studies must include between 5 and 25 participants. I conducted interviews with participants with the intent of achieving saturation of data. Saturation is typically obtained when the data provided from homogenously grouped study samples is rich and comprehensive (Bowen, 2008; Guest, Bunce, & Johnson, 2006). Saturation is achieved when no new themes emerge from participants during the data collection process (Saunders et al., 2017). Furthermore, saturation can be reached when additional coding is no longer feasible, and enough data is provided to ensure that the research questions can be answered (Hennink, Kaiser & Marconi, 2017). Failure to achieve data saturation can have significant influence on the quality of the research conducted and jeopardize results (Hennink et al., 2017).

**Instrumentation**

According to Bastos et al. (2014), instrument selection for data collection is an important stage in the research process. Instrumentation selection is important because the trustworthiness of the study partially relies on the instrumentation used to gather the

data that is used to address the research question. According to Brannen (2017), the researcher is the key instrument in collecting data in qualitative research. With interviewing being recognized as one of the most common data collecting instruments, the researcher holds the sole responsibility of collecting and analyzing data gathered from participants in qualitative research (Antwi & Hamza, 2015; Rubin & Rubin, 2012). What is more, Brinkmann (2014) explained the researcher should structure their research questions in such a way to gain as much knowledge about the phenomenon being explored as possible. Therefore, as the main research instrument of this study, I determined the content validity of the instrument by providing as a subject matter expert on the topic being explored.

According to Fusch and Ness (2015), interviews are one of the main instruments used by qualitative researchers to collect the data. Additionally, researchers suggest that a successful interviewer must ensure that interview questions are adequate by designing questions that are structured, clear, ethically sensitive, and relevant to the phenomenon being investigated (Harvard Sociology, n.d.). The instrument I used in this study included a list of semi-structured interview questions that I developed. I ensured that all semi-structured interview questions were study appropriate by making sure that all questions asked to participants were inviting, were structured with ethical sensitivity, and encouraged the participant to share information that directly supports my research inquiry. The semi-structured interview questions for this study consisted of open-ended questions. According to McIntosh and Morse (2015), open-ended interview questions provide interviewees with the freedom to elaborate on their experiences. Open-ended

interview questions also encourage examinees to provide strong, in-depth answers pertaining to the interview questions. Please refer to Appendix E for the list of semi-structured open-ended interview questions**.**

**Procedures for Recruitment, Participation, and Data Collection**

**Recruitment and participation.** I recruited participants from online forums and social media groups based in the United States. I sent letters to group and organization administrators to obtain permission to recruit participants through their organizations. Please refer to Appendix A for the permission letter to group and organization administrators for the recruitment of participants for this doctoral research study.

I obtained a letter of cooperation from groups and organizations that agreed to provide me with contact information or allow me to email their members. Please refer to Appendix B for the letter of cooperation. After obtaining approval to recruit from the targeted agencies, I asked group administrators to send out study invitation emails to their members as well as asked for their permission to recruit potential participants by posting study information to online community and social media group boards. See Appendix C for study invitation email/online forum and social media group post flyer. All emails and flyers for participant recruitment included my name, a pseudo phone number via Google Voice, and my university email address where potential participants could contact me directly to ask questions about the study. When potential participants contacted me regarding the study, I asked them to honestly answer predetermined prescreening questions in order to determine if they met the pre-established criteria for the study.

The following screening questions were asked to potential participants to ensure that they met the following inclusion criteria:

1 Are you an African American woman between 18 and 45 years of age?

2 Do you have a mother with borderline personality disorder or are you an African American woman seeking support from BPD-specific online or social media support groups?

3 Are you fluent in English?

4 Are you a resident of any part of the United States of America?

5 Are you willing to participate in an audio-recorded in-person interview or an audio-recorded telephone interview with me to discuss your experiences as an African American woman who has or had a mother with borderline personality disorder?

During the initial telephone contact with potential participants, I explained the details of the study and answered any questions from those who met the inclusion criteria. I also addressed confidentiality for participants so that they understood that their identities would not be revealed in the research reports. Prior to conducting the interviews, I clarified informed consent and what it entailed. I explained the informed consent form for telephone interviewees as well as described how the consent process would be documented. I provided this informed consent and consent processes by explaining the following to potential participants over the phone:

- The participant is being invited to participate in a research study,
- The participant understands the nature of the research study,

- The participant is made aware of my identity and institutional affiliation as the researcher,
- The participant is presented with a description of the type of questions to be asked,
- The participant understands that if sensitive questions are presented or if there are other risks entailed by participating, these will be clearly be addressed,
- A clear statement that participation is voluntary, and participants may withdraw from the study at any time without penalty,
- A clear statement that participation is confidential,
- A brief description of how the findings will be disseminated (journal articles, conference presentations),
- A notice that a backup audio recorder will be utilized during interviews.

I also notified potential research participants that they could contact me if they had any questions or concerns about the study. In order to explain and obtain informed consent for potential in-person interview participants, I informed them by phone that they would be required to review, sign and date an informed consent form before the interview. Prior to the interview, I let participants know that an informed consent form would be emailed to them, sent to them by postal mail, or handed to them in person based on their preference.

**Data collection.** The primary source of data collection for the study was in-person semi-structured interviews and one-on-one telephone-based, semi-structured interviews with eligible participants. According to Communications for Research (2016),

a researcher is at a disadvantage when conducting telephone interviews because unlike a face-to-face interview, the researcher cannot observe body language. On the other hand, an advantage for researchers conducting telephone interviews includes providing the researcher with the ability to reach samples over an expansive geographic area (CFR, 2016). In-person interviews hold advantages and disadvantages as a data collection method as well. According to Wyse (2014), personal costs may accrue for the researcher and the participant due to travel. Alternatively, in-person interviews allow the researcher to capture verbal and non-verbal cues such as body language (Wyse, 2014).

Prior to the interview, telephone interviewees received an informed consent form by email. I then followed up with potential participants through phone or by email to confirm that they received the informed consent form. During this period of communication, I addressed any questions, concerns or clarifications that potential participants may have had concerning the study. After I addressed the topic of confidentiality and participant informed consent, potential study participants were asked to sign and date two copies of the informed consent form (one signed copy for the participant and one signed copy for me) and return one of those signed forms to me through email. If participants did not return a signed informed consent form to me prior to their interview, I followed up with them via phone or email and again notified them of the crucial nature of signing and returning the informed consent form before the interview process. I also emphasized the voluntary nature of this study, and yet again assured them that there was no penalty for withdrawing from the study.

Once the informed consent form was collected, participants were given the choice

of picking a private, prearranged location where they would feel comfortable being interviewed (e.g. a private room at a local library or a private conference room in a hotel). Such locations, however, excluded any public places (e.g. coffee shops) or establishments that offer therapeutic or treatment services for family members of individuals who have BPD. This was to ensure that other people would not overhear participants' responses. Before the start of each in-person interview or telephone interview, I reviewed information regarding the study. I also reiterated the objective of the interview, explained the voluntary nature of the study, and reviewed the informed consent form. I explained to the participant that they had the right to discontinue the interview at any time without penalty or repercussion. Participants were informed that the interviews would last between 30 and 60 minutes. I explained to participants that I might contact them with a follow up phone call in the event that I had questions about the information provided or if I needed for them to clarify or confirm any material that they provided.

All interviews were audio-recorded upon the participant's permission. I also used an iPad to record the interviews as a back up recording devise. I manually transcribed all audio-recorded interviews precisely as participants articulated. During the data collecting and data analyzing stages of the research process, I used a reflexive journal to assist in limiting my biases by recording my personal experiences, perceptions, thoughts, and sentiments, which contributed to the general write up of the research (see Houghton et al., 2013).

After each interview had been completed, participants were given the opportunity to add any further information that they believed may be relevant to the disclosure of

their experiences with the phenomenon. Additionally, participants were made aware by phone or email that a summary of findings from the study would be available to them after my dissertation has been approved. Participants were informed that a copy of the interview transcript would be sent to them via email so that they can check for accuracy, which is referred to as member checking in qualitative research. According to Birt, Scott, Cavers, Campbell, and Walter (2016), member checking is a validity technique used by researchers to ensure that data is accurately obtained during the data collection. This method is also known as participant or respondent validation. Member checking requires researchers to return data or results to participants so that participants have the opportunity to review the information for the accuracy of their experiences (Birt et al., 2016). During the process of member checking, I contacted participants so that they can review my summary of their written transcribed interview questions and responses. I also sent them a copy of their unprocessed transcribed interview questions and answers. I communicated with participants by sending them an email explaining the process of member checking, how to conduct such, and how to return the document back to me through email. Please refer to Appendix E for the e-mail explaining the process of member checking to participants.

**Data Analysis Plan**

Audio recordings of the interviews were uploaded into Express Scribe for manual data transcription. After all recordings were uploaded, I transcribed the audio recordings of the interviews into a text-based document. I created tables in Microsoft Word were I imported, categorized, organized and coded all the data through an inductive approach. I

used open coding, axial coding, and selective coding to systematically code emergent themes using Colaizzi's modified seven-step process for analyzing the data (Carpendale, Hinrichs, Knudsen, Thudt, & Tory, 2017; Cho & Lee, 2014; Morrow, Rodriguez, & King, 2015; Saldaña, 2015). All notes recorded in my reflexivity journal during interviews were typed onto my laptop computer, imported and organized in Microsoft Excel, and subsequently stored in a separate folder on my laptop computer.

## Issues of Trustworthiness

According to Graneheim and Lundman (2004) credibility, dependability, confirmability and transferability have been used to describe various aspects of trustworthiness in qualitative research. The findings of the study are truthful. Trustworthiness enhances the validity of results from a qualitative inquiry (Erçetin & Banerjee, 2015). Moreover, Connelly (2016) explained that trustworthiness in qualitative research ensures that research study findings are accurate.

### Credibility

Credibility has been described as the integrity of the data (Tracy, 2010). Credibility is a criterion in qualitative research that is obtained when participants agree with the interpretations of the researcher's findings (Noble & Smith, 2015). To establish credibility in this study, I used triangulation, researcher reflexivity, and member checking. Triangulation requires a researcher to combine two or more data sources, theoretical outlooks, or analytical methods within the same study to gain a more comprehensive understanding of the phenomenon being researched (Carter, Bryant-Lukosius, DiCenso, Blythe, & Neville 2014). The purpose of using triangulation was to

enhance the credibility of results by comparing information from various sources (Carter et al., 2014). I triangulated multiple sources of information in Chapter 5 where I compared and contrasted existing literature on the topic addressed in Chapter 2, the theoretical orientation of this study, and the findings from this study.

I also enhanced credibility of the findings through member checking, which consisted of me asking participants to verify the accuracy of the transcribed interview data (Erçetin & Banerjee, 2015). I provided directions for member checking to participants in an email that explained to them the following: (a) how to go over my written interpretation of the data, (b) how to approve of my explanations of their experiences, (c) how to make corrections to my findings whereupon they would use a different font color to distinguish their corrections, and (d) how to then return their feedback to me via email. See Appendix E for the member checking instructional email/letter for study participants.

**Transferability**

Transferability describes the extent to which others could potentially transfer or apply findings from a study to conditions outside of the study (Erçetin & Banerjee, 2015). I employed purposeful sampling as a strategy to increase transferability for this study. *Purposeful sampling* is used when a researcher deliberately selects a small number of study participants that meet particular criteria pertaining to a research inquiry. The purpose of purposeful sampling is found in the understanding that the technique allows researchers to choose information-rich cases (e.g., participants, settings) for a detailed study (Etikan, Musa, & Alkassim, 2016).

I also enhanced the transferability of findings from this study through the use of thick-text descriptions. Tracy and Hinrichs (2017) explained that thick descriptions allow the researcher to relay in-depth accounts, depictions, and descriptions of participants' responses. The written transcripts provided the source for the thick-text descriptions. Amankwaa (2016) posited that thick description provides as a way of achieving a form of external validity. By describing a phenomenon in considerable detail, the reader can begin to evaluate the extent to which the study findings are transferable to other times, settings, situations, and populations (Amankwaa, 2016; Tracy & Hinrichs, 2017).

**Dependability**

Dependability is achieved when the researcher's study findings are consistent and can be replicated by future researchers (Amankwaa, 2016). Dependability is crucial in enhancing trustworthiness in qualitative inquiry because it assures subsequent researchers that if they were to examine a study's data, they would arrive at similar findings, understandings, and conclusions about the evidence (Cope, 2014; Leung, 2015). One of the most beneficial ways to establish dependability is to establish an audit trail. According to Anney (2014), an audit trail involves an examination of the research process and findings to validate the data, by which the researcher explains all the research justifications and procedures to show how the data was gathered, documented and analyzed.

Information incorporated in the audit trail included the design of the study, the research method, procedures used to gather and handle data, and notes related to researcher reflexivity as well as other relevant occurrences (see Rodgers & Cowles,

1993). In addition to an audit trail, I utilized a dependability audit. According to Houghton et al. (2013), a dependability audit trail serves as a series of evidence that the researcher remained true to academic and ethical requirements in conducting the research. Thus, an independent auditor (my dissertation methodologist) reviewed my audit trail. Research activities for review included but were not limited to (a) field notes recorded in the audit trail, (b) participant and researcher correspondences, (c) and descriptions. I also enhanced dependability of the findings through member checking, which consisted of asking participants to verify the accuracy of the transcribed interview data (see Erçetin & Banerjee, 2015).

**Confirmability**

Confirmability in qualitative research refers to how accurately findings reflect participants' narratives (Nicholls, 2017). I established confirmability by using strategies such as listening to interview recordings several times in order to accurately transcribe data, observe researcher reflexivity and assure research validity through triangulation (see Anney, 2014; Morse, Barrett, Mayan, Olson, & Spiers, 2002). Reflexivity is also a technique that is valuable to confirmability in phenomenological research. Reflexivity requires a qualitative researcher to examine his or her own experience and views to see how they influence aspects of the research process such as topic selection, choice of research methodology, data analysis, interpretation of results, and presenting the study findings (Berger, 2015; Teddlie & Tashakkori, 2009). Thus, maintaining a reflexive journal helps researchers to achieve reflexivity. In keeping a reflexive journal, I recorded my reflections and my experiences during the research process with regards to my biases.

I was careful to state my previous experiences with the explored human phenomenon so that the reader understands my position on the subject and is aware of any partialities or subjective suppositions that may impact the trustworthiness of the study. I also listened to interviews several times in order to ensure that findings were not subjectively interpreted, rather were grounded on participants' responses (see Anney, 2014). To achieve triangulation I merged data sources, theoretical outlooks, and analytical methods within the same study to gain a more extensive understanding of the phenomenon being investigated (see Amankwaa, 2016).

## Ethical Procedures

As a National Institutes of Health Extramural Research Office certification holder, I have been trained in protecting human research participants. Please refer to Appendix F for my National Institutes of Health Extramural Research Office certification**.** While engaging with participants, I applied professional, ethical standards established by the American Psychological Association for implementing ideal methods associated with psychological activities in research. I used the following ethical practices to guide my research endeavors: (a) obtain appropriate institutional approval before conducting a study, (b) receive all informed consent forms from participants, (c) obtain consent for audio or visual recordings, (d) disclose the nature of the study to participants, (e) conclude that all participants participated in the study under their own volition, and (f) allow participants to have the option to discontinue the study at any point in time without reprisal (American Psychological Association, 2010).

Before collecting data for this study, I obtained approval from the Walden University Institutional Review Board (IRB). The IRB approval number for this study is 06-05-19-0465129, and it expires on June 4, 2020. I also obtained permission or a letter of cooperation from each agency that I attempted to recruit participants from. Ethical concerns relating to the recruitment materials and processes for this study included privacy, imposed pressure or undue influence, misleading description of the study, biased presentation of the study, and the therapeutic misconception of the study (see Appelbaum, Anatchkova, Albert, Dunn, & Lidz, 2012; Williams & Walter, 2015). In order to circumvent such issues, I disclosed to participants that although the possibilities of ethical research concerns or issues may arise, as the researcher I would (a) respect their privacy, (b) abstain from placing pressure or undue influence on their decision to participate in the study, (c) accurately and clearly describe the study, (d) remain impartial once the study is presented, and (e) disclose that the study in no manner substitutes for or gives any pretense of a therapeutic intervention. Participants were also informed of the voluntary nature of this study and were assured that they had the option to withdraw from the study at any time. In addition, I sent participants an email with a list of online and in-person free and affordable costing counseling resources as well as recommended books on how borderline personality disorder impacts families. Please refer to Appendix G for the list of free and affordable costing counseling resources and recommended books for participants.

In order to maintain the privacy and confidentially of the participant, I replaced all interviewee names with “Participant” along with an accompanying number. For

example, instead of listing the participant's name when transcribing the interviews, I listed interviewees as "Participant 1", "Participant 2", "Participant 3" and so on. I also referred to study participants as their assigned pseudonyms rather than their names during the recording of their interviews. To further protect the privacy and confidentiality of the participants, each study participant had a paper file as well as a digital folder on my personal laptop computer. All research related documents and data recorded on paper files were scanned onto my personal laptop computer and were stored in individual digital folders for participants. All information in participants' individual digital folders was stored on my laptop computer in a password-protected file. Paper files were secured and stored away in a locked file cabinet at my home. Data recorded on my iPad and my digital audio recording device were uploaded onto my laptop and stored in each participant's digital folder. Data was erased from my iPad and digital audio recording device after each computer upload. The iPad and digital audio recording device was maintained in the locked briefcase when not being used for interviews. I am the only individual who has access to the data. I am also the only person who has access to the laptop computer along with passwords that safeguard files with study information and data. All paper files, digital folders, research data and records will be stored for a period of 5 years, after which they will be destroyed according to Walden University's research protocol. If any adverse ethical issues were to arise as a result of the study, I would have proceeded to contact my dissertation committee as well as the IRB.

## Summary

In this chapter I presented the research design, methodological choices, and potential issues of trustworthiness. I also discussed the procedures used to collet data for this phenomenological study on how experiences associated with being raised by a mother who has borderline personality disorder affected subsequent adult attachments for African American women. Additionally, I addressed ethical concerns. In Chapter 4, I further discuss the research setting, demographics of participants, data collection methods, trustworthiness of the study, and present an in-depth thematic analysis.

# Chapter 4: Results

## Introduction

In this study, I explored how the experiences of being raised by a mother diagnosed with BPD affected subsequent adult attachments for African American women. I used the following research question to guide this study: How did the experiences of being raised by a mother with BPD affect subsequent adult attachments for African American women? In this chapter I discuss the research study setting, the demographics of participants using pseudonyms, and the method for data collection. I also describe the data analysis procedures I used. Furthermore, I present evidence of trustworthiness and themes that emerged from the analysis of the data as well as a summary.

## Setting

I conducted interview sessions over the phone as well as in person at locations chosen by participants. All study participants chose the time and the setting in which they felt most comfortable. To my understanding, there were no other individuals by the participant or myself during each interview. Furthermore, to my knowledge, there were no personal or professional conditions that influenced participants, their knowledge of the study, or my subsequent interpretations of the data. To ensure confidentiality for the participants, pseudonyms were assigned to participants of this study, where they were identified as *Participant* along with an accompanying number (e.g., Participant 1, Participant 2, Participant 3, etc.).

## Demographics

The data collection process consisted of gathering basic demographic information for each participant, which included race, gender, and age. Participants for this study were all African American women between 18 and 45 years of age who have mothers with BPD. Eleven women participated in this study. Nine out of 11 participants learned of their mothers' BPD diagnosis after the age of 18, while two participants learned of their mothers' diagnosis when they were under the age of 18. Eight of the participants had medical backgrounds, academic backgrounds in the study of medicine or psychology, or had interests in pursuing medicine or working in the field of psychology. Six of those eight participants credited their experiences with their mothers as an influential factor for their academic pursuits and research endeavors in psychology and mental health studies.

## Data Collection

Over a 5-week period, I conducted six telephone interview sessions and five in-person interview sessions at various locations, including a private room in a coffee shop and in the homes of study participants. Telephone interviews lasted between 24-90 minute, and in-person interviews took between 15-25 minutes to complete. An iPad along with a digital audio recorder were used to gather the interview data. I also used the interview guide to notate meaningful information expressed by participants during the interviews. Data collection procedures did not deviate from the plan presented in Chapter 3, nor did I encounter any unexpected or unusual circumstances during the data collection process.

## Data Analysis

While analyzing the data, I employed an inductive approach to the data analysis. This approach allowed me to identify themes that emerged from the data. To analyze the data, I used Colaizzi's seven-step method as outlined in Chapter 3. According to Colaizzi (1978), the researcher should read interview transcripts for descriptive statements and then group these statements into categorical themes until no new themes emerge.

During the open coding process, all interview questions generated emergent themes and subthemes. I then used axial coding and selective coding to code segments of text that related to the themes. I created tables in Microsoft Word in order to format the categorized axial codes, open codes, and key words and phrases. In the event that a participant disclosed any type of sensitive or identifiable information (e.g., a participant referred to their mother by name), I redacted the sensitive or identifiable information in order to protect the privacy of the participant as well as others directly or indirectly related to the study.

## Evidence of Trustworthiness

According to scholars who study ethical research practices, in order to evaluate the trustworthiness of a study, the researcher should assess the details of the research as well as the ethical conduct carried out by the researcher towards the study participants (Rallis, Rossman, & Gajda, 2007). The findings of this study are based on truthful accounts as expressed by study participants. I followed the criteria established in Chapter 3 in order to evaluate the credibility, dependability, confirmability, and transferability of this study.

## Credibility

Credibility is achieved when participants agree with the interpretations in the researcher's findings, and it subsequently allows readers to use the study findings to make an informed decision (Noble & Smith, 2015; Tracy, 2010). I purposively recruited individuals with critical information to participate in the study. I recorded my observations, thoughts, and feelings in a reflexive journal in order to acknowledge any biases that I had. I used methods of triangulation, which included multiple sources of information. I used the process of member checking and provided participants with a copy of their transcribed interview in order to make certain that I accurately captured their experiences. I also maintained an audit trail of all the documents related to the research study.

## Transferability

When researchers describe a phenomenon in substantial detail, it allows the reader to determine the extent to which the study findings are generalizable to other settings (Amankwaa, 2016; Tracy & Hinrichs, 2017). In order to enhance transferability, I used thick text descriptions to describe the findings of the study so that readers can ardently connect with the study. I explained the manner in which participants were recruited to participate in this study as well as how the data were collected, coded, and analyzed. I furthermore maintained an audit trail of the interview recordings, interview notes, and a reflexive journal containing my thoughts and feelings while conducting the research.

### Dependability

According to Amankwaa (2016), the results of a study are considered dependable if subsequent researchers can duplicate the findings. To enhance dependability of the findings, I maintained an audit trail containing all research documents pertaining to this study such as informed consent forms, the interview protocol, and interview audio recordings, and I transcribed interviews and notes and stored them in a secured location. I also used feedback from my dissertation methodologist as a dependability auditor in order to acknowledge any concerns in the study.

### Confirmability

According to Nicholls (2017), research confirmability refers to how precisely study findings reflect participants' accounts. In a secure manner, I maintained an audit trail of notes taken during the interviews, interview audio recordings, and participants' interview transcripts and stored this information in a private location. I also recorded my thoughts, feelings, and observations of participants as well as my surroundings in my reflexive journal while collecting the data. To achieve triangulation, I merged multiple sources of information including literature on the topic addressed in Chapter 2, the theoretical orientation of this study, and the findings from this study.

## Results

The research question I addressed was the following: How did the experiences of being raised by a mother diagnosed with borderline personality disorder (BPD) affect subsequent adult attachments for African American women? A table of axial codes, open codes, and key words and phrases introduces the results for each interview question.

Each table is accompanied by a brief description of major themes and subthemes pertaining to interview questions related to examining the research question. The findings are structured around the attachment experiences of African American women who have mothers with BPD.

**Learning of Mother's Diagnosis**

One interview question asked participants how they found out about their mothers' diagnosis. Table 1 presents a summary of the results. The two emergent themes were that participants learned of their mothers' diagnosis through formal means or by informal means. Several key words and phrases were coded to those emergent themes.

Table 1

*Themes for How Participants Learned of Mothers' Diagnosis*

| Axial Codes (Themes) | Open Codes (Subthemes) | Key Words and Phrases (Codes) |
|---|---|---|
| Formal Diagnosis | Medical professional | heard that from a doctor<br>the psychiatrist came to that diagnosis<br>mom told me medical professionals suspected she had BPD |
| | Medical records | shared her medical paperwork with me with the diagnosis on it<br>mom's medical records confirming her illness<br>by combing through her paperwork |
| | Therapist | therapist concluded<br>mental health counselor explained<br>accompanied her to therapy appointment |
| | Comorbid diagnoses | she had multiple diagnoses<br>first diagnosed with bipolar disorder<br>narcissistic personality disorder<br>also diagnosed with depression |
| Informal Diagnosis | Self-knowledge | psychology major<br>medical school |
| | Independent research | watching an interview with Brandon Marshall<br>conducted some research of my own to better understand mother's behavior |
| | Family member | my mother shared the information<br>my grandmother told me<br>my dad described it to me |

**Theme 1: Formal Diagnosis.** The first theme that emerged for the question regarding how participants learned of their mothers' BPD diagnosis was participants learning of their mothers' diagnosis through a formal means. This discovery included participants finding out that their mothers had BPD through a medical professional, medical records, or clinicians, with a few participants divulging that their mothers had comorbid diagnoses in addition to BPD.

A few participants shared how they discovered that their mothers had BPD through a medical professional. For instance, Participant 4 recalled how she accompanied her mother to a psychiatric appointment, and shared that it was during that visit that her mother's doctor diagnosed her with BPD. Participant 10 revealed in the following comments how she learned of her mother's diagnosis: "She went to a community-based healthcare center that was government funded. That's where a mental health counselor explained to her that she has borderline personality disorder. Then, she followed up with her doctor and mentioned the diagnosis. And so she shared her medical paperwork with me with the diagnosis on it."

Participant 2 further explained:

> "I think it was through one of those really quick and hurried conversations of trying to get a doctor on the phone, trying to speak to someone that they said, 'um, borderline personality disorder is the diagnosis'. So when I heard that from a doctor, I heard those three words."

Some participants shared that they learned of their mothers' BPD diagnosis through medical records. Most notably, Participant 1 revealed how she learned of her

mother's diagnosis through medical paperwork: "I was actually helping her look through some paperwork; reading through, skimming through, being nosy and combing through paperwork and I saw her diagnosis."

A couple of participants revealed that they heard of their mothers' diagnosis through other formal means such as through a therapist. For example, Participant 9 revealed during her interview that her mother's agreement to seek therapy for emotional and behavioral support lead her mother's therapist to the conclusion that her mother had BPD. Participant 9 provided the following response: "My mother agreed to see a therapist to help her sort through her feelings, behaviors and thought patterns. That's when the therapist concluded that she had borderline personality disorder." Participant 11 explained how describing her mother's behaviors during her personal therapy sessions lead her therapist to provide her with the knowledge that her mother has borderline personality disorder. She shared:

> "I found out about my mother having borderline personality disorder from describing my mother's consistent behaviors over a period of time to my therapist. My therapist said that he believed that my mother has borderline personality disorder. He said that is more than likely what my mother has because he's worked with those patients before."

Other participants shared how their mothers' had comorbid mental illness diagnoses. Such was the case for Participant 2, as she revealed during her interview:

> "She's had multiple diagnoses over the years that I know of. Um, everything from major depression, seasonal depression, severe anxiety, um, intermittent explosive

> disorder, just to name a few. And I'm sure there's way more than that, but those are the ones I know of."

Participant 7 described how her mother's BPD diagnosis enlightened her to the understanding that her mother had bipolar disorder and comorbid BPD. Participant 7 explained: "She had her first diagnosed mental illness of bipolar disorder, and then she mentioned that a medical professional suspected that she also had BPD. So, this was all confirmed."

**Theme 2: Informal Diagnosis.** Several participants also revealed they learned about the diagnosis through an informal means. A couple of participants indicated that they came to understand that their mother had BPD due to their professional knowledge of BPD or their prior familiarity with the mental illness. Participant 8's response indicated that she learned of her mother's diagnosis because of her medical school training, which provided her with prior knowledge of BPD. Participant 8 stated:

> "I was in medical school, and I already studied psychology because that was one of my majors in college. So considering my personal experience with studying this material, I basically supported her doctor's conclusion that she has borderline personality disorder."

Participants also revealed that they learned of their mothers' diagnosis through independent research efforts. They reported on specific instances that inspired them to explore the atypical experiences that they had with their mothers by way of personal research prior to their mothers receiving an official diagnosis. Participant 6 recalled

viewing a television interview with a celebrity athlete where he talked about his BPD diagnosis motivated her to conduct her own research on the disorder. She explained:

> "I was watching an interview on TV with Brandon Marshall the football player. He was doing an interview and he was discussing how he has BPD. He was just talking about the things that he had gone through and how he felt, and it sounded so familiar to me. So I just went ahead on and I goggled a little bit more and I was like 'wow, this is how my mother acts!' And this was a little bit before my mother had went to a doctor."

A few participants also shared that information about their mothers' diagnosis of BPD came from the disclosure of a family member; such was the case with Participant 3, who indicated that her grandmother told her about her mother's BPD diagnosis. Participant 5's comments below revealed how she learned of her mother's diagnosis of BPD through her father:

> "When my dad described it to me, he described it in kid's terms. He basically just told me that people have chemicals in their brains and sometimes for everybody it's not always the same. Sometimes some people are lower and others are higher and that affects on how they act and the things that they do."

**Thoughts on Mother's Diagnosis**

Participants were asked to describe their thoughts when they found out about their mothers' diagnosis. Table 2 presents a summary of the results. The three main emergent themes summarized that participants believed that their mothers' diagnosis was accurate; participants believed the BPD diagnosis affirmed their experiences with their mothers;

and participants had unsettling thoughts mothers' mental illness. Numerous key words and phrases were coded to the emergent themes.

Table 2

*Summary of Themes for Participants' Thoughts on Mother's Diagnosis*

| Axial Codes (Themes) | Open Codes (Subthemes) | Key Words and Phrases (Codes) |
|---|---|---|
| BPD Diagnosis Was Accurate | Diagnosis provided clarity on mother's behavior | it just explained a lot/made more sense<br>diagnosis was very accurate<br>that labeling it made it real<br>how my mother was acting was because of diagnosis<br>all the experiences I've had we're legitimized<br>a moment of clarity for me<br>knew her behavior just could not be normal |
| | Treatment for mother | prepare for planning and treatment for mother<br>therapist will treat her<br>get the help that she needs |
| Diagnosis Was Affirming | Validating | vindicated/excited<br>everything was starting to make sense<br>knowing something was not right was affirmed by therapist<br>my mom was not like every other mom<br>feelings towards her were justified<br>knew something wasn't right<br>I wasn't making things up<br>wasn't just a situational thing<br>assumptions and gut feeling was right<br>I was not the cause of all her problems |
| Unsettling | Confused | couldn't really comprehend it<br>had a lot of questions<br>what it meant for my mother to have BPD<br>what is this diagnosis about |
| | Desire for no diagnosis | no one wants a parent that has problems like that<br>you don't want anything to be wrong with your parents<br>no one wants to be mentally ill<br>no one wants their Mom to suffer<br>wish she didn't have it/denial |

**Theme 1: BPD Diagnosis Was Accurate.** The first theme to emerge was participants' belief that a borderline personality diagnosis for their mothers was accurate. Several participants reported that the diagnosis of BPD helped them better understand their mothers' unusual behaviors. Participant 1 explained her initial reaction once she learned of her mother's BPD diagnosis:

> "It was just a moment of clarity. Um, it explained my mom's, um, erratic behavior, like basically you know like her mood swings, um, being self-absorbed at times…it just explained a lot;"

Participant 4 disclosed that she felt her experiences with her mother made sense to her once she learned of her mother's BPD diagnosis. Participant 4 stated during her interview "Everything now had a name…labeling it made it real, you know?"

Participants additionally recalled having supportive thoughts about the prospect of their mothers receiving treatment and therapy. For instance, upon hearing of the diagnosis, Participant 8 recalled having faith that a therapist will subsequently treat her mother. Participant 1 expressed a similar thought, stating: "Just to know that there-that there is a- a diagnosis and you know-so that means that there can be, you know subsequent planning and treatment to follow."

**Theme 2: Diagnosis Was Affirming.** Some participants expressed that their mothers' diagnosis validated the experiences that they had with their mothers and legitimized their assumptions about their mothers' unstable mental state and confusing behavior demonstrations. For example, Participant 5 commented that her mother's BPD

diagnosis affirmed her longstanding belief that her mom "was not like other moms". Participant 10 revealed:

> "I was scared and relieved at the same time that my mother's bouts of anger, mood swings, sadness, threats of suicide, and for a lack of a better word craziness finally had a name. I was relieved that now I knew that all this time I was not the cause of all her problems like she made me out to be."

Participant 7 also recalled how her mother's diagnosis gave her a more understanding perspective of her disordered mother-daughter experiences; she disclosed the following during her interview:

> "The diagnosis made sense because I knew that something wasn't right and it made a lot of sense. It was scary too because I experienced her behavior and I knew that my experiences with my mom were not normal at all."

Participant 2 recalled thinking that her assumptions about her mother's anomalous behavior and unstable mental state were validated by the medical diagnosis. Participant 2 revealed: "I actually felt, um, satisfied in a way that, you know all my assumptions about my mother's unpredictable and dangerous behaviors and my, um just my gut feeling was-was right. I'm not a bad daughter or bad child with me feeling the way I felt towards her."

**Theme 3: Unsettling.** The third major theme to emerge from this enquiry included participants having unsettling thoughts about their mothers' diagnosis. While participants were appreciative and hopeful once their mothers had an official diagnosis of

BPD, participants dually expressed being confused about their mothers' illness as well as having a desire for their mothers not to have BPD.

Having thoughts of confusion was also a shared experience among participants. Participant 5 indicated during her interview that because she was so young, she couldn't really comprehend her mother's diagnosis. Participant 9 recalled feeling wondered if her mother's behavior could truly be explained by a BPD diagnosis as she indicated the following:

> "When I first heard the diagnosis I wondered what it meant for my mother to have BPD. I wondered if the diagnosis was truly tied to all the times she displayed erratic, selfish, and downright dangerous behaviors that I just could not wrap my head or heart around."

Participant 7 remembered questioning the next course of action upon finding out about her mother's diagnosis; she shared: "I wondered, what is this diagnosis about and what are we supposed to do now? Now what? What does this all mean? I think those were the biggest questions."

Several participants reported having resentful thoughts towards having a mother with BPD. This was the case for Participant 7, who stated: "I mean no one wants a parent that has problems like that." Participant 5 similarly noted during her interview: "No one wants their mom to suffer and no one wants to have to deal with that, so it was different." Participant 8 expressed similar sentiments as she stated: "Obviously you don't want anything to be wrong with your parents, you want them to be healthy." Participant 3 poignantly stated during her interview: "I wish she didn't have it."

Participant 11 shared that while her mother's diagnosis excited her because it offered her an understanding of her mother-daughter relationship experiences, she soon after experienced denial towards her mother's mental health condition. She stated:

> "My first thought was excitement because I had been trying to discover what was broken all of my life between she and I. So there was some relief there but after that settled down, it was a denial for a while. It was difficult."

**Feelings About Mother's Diagnosis**

Participants were asked to describe how they felt when they found out about their mothers' diagnosis. Table 3 presents a summary of the results. Two emergent themes included participants dually felt displeased about their mothers' mental health condition as well as compassion and supportive for their mother. Numerous key words and phrases were coded to those emergent themes.

Table 3

*Summary of Themes for Participants' Feelings About Mother's Diagnosis*

| Axial Codes (Themes) | Open Codes (Subthemes) | Key Words and Phrases (Codes) |
|---|---|---|
| Displeased | Unhappiness | there was like a sadness/upset/disheartening<br>made me kind of feel like angry<br>unfair to my me, mother and family<br>felt sorry for her |
| | Disheartenment | wish I knew earlier<br>going to be really hard for me<br>depressed<br>angry/blamed her<br>really ashamed<br>this isn't right<br>robbed of a healthy mother-daughter relationship<br>discouraged |
| Compassionate And Supportive | Sympathy for mother | don't think that she does it with malicious intent<br>don't think that mom ever healed from the trauma in her childhood<br>can't imagine her living with these thoughts and thought patterns and ideas<br>felt bad for her<br>made me more understanding of my mom |
| | Supportive of mother | be there for her/support her<br>she'll get through this<br>everything will be ok |
| | Hopeful for mother | made me happy<br>we can get help<br>there's actually a solution<br>must be treatment and hope for my mom |

**Theme 1: Displeased.** A major theme to emerge was participants feeling displeasure towards their mothers' diagnosis. They expressed the disappointment that they had because they had a parent who struggled with and ultimately received an official

mental illness diagnosis. For instance, Participant 5 disclosed during her interview: "At that point, it was a lot of things that she had done. So, it made me sad. At that age it made me sad. There was like a sadness, almost until like I was a teenager pretty much..." Participant 11 explained how knowledge of her mother's diagnosis made her feel as if she was deprived of having a healthy mother-daughter relationship. She explained:

> "It sent me into a depression. I was depressed and then I was angry. I went to a period of time where I was stuck on the rage for a while because I felt robbed of a healthy relationship with my mom."

Participant 7 expressed feelings of anger by indicating the following: "I really didn't understand the diagnosis itself but in terms of how I feel about her getting that diagnosis, it made me kind of feel like, angry." Similarly, Participant 9 indicated how she felt like her mother's diagnosis was unfair to her, her mother, and her family. .

Several participants also felt that learning of their mothers' diagnosis earlier than they did could have helped them better interact with their mothers. For example, Participant 2 explained how she felt that understanding that her mother had a mental illness at a younger age could have benefited how she interacted with her mother. She provided the following response: "I just wish I'd known earlier because I I've really struggled. I've always struggled with our relationship. But it would have been nice to have this knowledge base, you know, fifteen years ago so I had something to work through therapy back then." Upon learning of her mother's diagnosis, Participant 3 recalled feeling discouraged in believing that her subsequent mother-daughter experiences were going to be "really hard" for her to endure.

Participant 5 recalled feeling dispirited once she learned of her mother's disorder. She expressed the following during her interview:

> "Well, like when she would react or she would blow up or she would go through like an episode and everything it would just scare me. I used to get sad, mad and depressed because sometimes she would take it out on my sister and me. I just felt discouraged all the way around."

**Theme 2: Compassionate And Supportive.** Having compassion and supportive feelings towards participants' mothers was another significant theme that emerged the thematic analysis. Some participants recalled having feelings of compassion such as sympathy towards their mothers after learning of their mothers' mental health condition. They explained how having feeling sympathy towards their mothers encouraged them to be mindful of the challenges that their mothers seemingly endure as a result of having a mental health affliction. For instance, Participant 4 stated: "As much as the negative symptoms can negatively and severely affect me, I can't imagine her mental state living with these thoughts and thought patterns and ideas."

Participant 10 relayed how her mother's BPD diagnosis provider her with clarity and inspired her to lend sympathy to her mother. She explained during her interview:

> "It made more sense; it made me more understanding of my mom. To be honest, I had some sympathy for her. I felt bad for her on some level because I can only imagine what it's like to have a mental illness that you sort of, you know, can't control."

Participant 1 explained how her understanding of her mother's unaddressed early childhood trauma that likely lead to her mother's BPD diagnosis made her feel because there was a traceable pattern of events that could explain her mother's current state.

A couple of participants also recalled feeling supportive of their mothers. Participant 1 communicated a stance of support in the following comment:

> "Um, I felt glad that she does have a diagnosis and that, you know, she's seeking treatment for it. My feelings were more supportive. I had to remind myself not to judge her. But I knew that I just had to love her and be there for her as much as I can".

Participant 8 expressed feeling a hopeful for her mother getting help upon learning of her mother's diagnosis; she stated the following:

> "After learning that my mom had borderline personality, I felt like 'ok, now we can move on, we can get help'. So that was a big relief. It was a big relief especially because you know something is wrong and you want to have an explanation for it. That's how you can treat it and heal."

Participant 6 explained that learning of her mother's diagnosis gave her hope for more family discussions about mental illness and here her mother could receive treatment. Participant 6 indicated:

> "Honestly the diagnosis made me have more sympathy for her because mental health in our family is not something that's really talked about. So I was actually encouraged in understanding that my mother was in fact sick and this was not a

way of life, because that meant that there must be treatment and hope for my mom whether she gets it or not."

**Nature of Relationship After Learning Mother's Diagnosis**

Participants were asked to describe how their relationships with their mothers changed after they learned of their mothers' diagnosis of BPD. Table 4 presents a summary of the results. Emergent themes from this question included some participants reporting that their relationship with their mothers became more difficult, or in some cases did not change, while some participants shared how they modified how they related to their mothers. Key words and phrases that were coded to those emergent themes are also presented in Table 4.

Table 4

*Summary of Themes for Nature of Relationship After Learning of Mother's Diagnosis*

| Axial Codes (Themes) | Open Codes (Subthemes) | Key Words and Phrases (Codes) |
|---|---|---|
| More Difficult | Hard | it just got really hard<br>difficult to relate to mother<br>changed a lot in how I choose to engage |
| | Has not changed/improved | nothing changed<br>never bonding prior to diagnosis<br>remind myself that she actually is mentally ill<br>hard to change her whole style |
| Modified How Participants Related To Mother | More understanding | can better interact in certain situations with her<br>treat her basically as her illness<br>don't take what she does personally<br>learned more about the diagnosis in order to relate to her<br>more patient with her and understanding |

**Theme 1: More Difficult.** Some participants shared that although knowing of their mothers' diagnosis helped them understand how to relate to their mothers, having a mother with BPD made it more difficult for them to establish close mother-daughter bonds. For instance, Participant 3 explained during her interview: "It just got really hard to, I guess have a mother-daughter relationship with her." Participant 9 described how having a mother with BPD can be difficult when it comes to understanding and identifying with her mother. Participant 9 shared:

> "In the earlier years her behaviors would emotionally and psychologically torment me; but I am grateful that I allowed myself to better understand her rather than hate her or totally cut her off. But I will not lie, it can still be incredibly hard sometimes to relate to her as my mother or even try to understand her at times."

A couple of participants revealed that their relationships with their mothers have not changed or improved since they learned about their mothers' diagnosis. Participant 2 revealed such in the following response:

> "Oh it hasn't. It hasn't. Everything, all of her patterns were just too formed at that point. I only actually recently found out maybe about 6 to 8 months ago about her actual diagnosis. So again, it's just been like this for years. I've had to process or try to work through so many difficult things that I experienced with my mom. But yeah, no nothing changed."

Participant 11 similarly expounded her mother-daughter relationship experiences prior to as well as after learning of her mother's diagnosis. She explained:

> "None. Zero. Prior to her diagnosis there was never any bonding to speak of. Everything always revolved around her and her needs. Since the diagnosis, I found that I could now go through the process of healing and understanding the dysfunctional nature of our relationship and also the abuse. So I've pulled back quite a bit emotionally and psychologically."

**Theme 2: Modified How Participants Related To Mother**. Some participants reported that learning of their mothers' diagnosis caused them to adjust the way in which they related to their mothers. The most notable modifications included being more understanding of their mothers' behavior and acknowledging the influence that their mothers' diagnosis had on their mother-daughter interpersonal experiences. Participants additionally shared that knowing of their mothers' diagnosis provided them with insight on how to interact with their mothers as well as helped them exercise patience for their mothers. Participant 5 explained how discovering that her mother had BPD hanged the way she interacted with her mother. Participant 5's indicated the following:

> "When I was younger I didn't understand it. I just thought she was difficult; she was angry; she was crazy. And I hate to use that word for this diagnosis, but I remember being a teenager and saying that my mom is crazy around everybody, and everyone was like 'yeah your mom is kind of crazy'. But, I guess now that I'm older I kind of-you can prepare for it. You know how to interact in certain situations with her. You know how to tell her one thing to get this kind reaction and you know how to tell her another thing to get another reaction."

Participant 10 explained how learning of her mother's diagnosis of BPD enabled her to me more understanding:

> "I was more patient with her and understanding about why her behavior was the way it was. I also know that she grew up without a father and her mother had addiction issues and was an alcoholic and barely raised her. So, coming from a background of a broken home coupled with my mother's history of being neglected and abandoned by her parents, I could better understand how this type of personality disorder would form in someone like her. So, it still makes me feel bad when she's negative towards me, but I don't get as angry or hurt as much or as deeply."

Participant 7 similarly reported how her mother's diagnosis of BPD helped her not to personalize some of the negative treatments that she received from her mother as she disclosed during her interview:

> "It's changed how I internalize our engagement and I'm really grateful for that. I don't take what she does personally. For example, this morning I talked to her and she did something completely insensitive. Now, 10 years ago I would've been depressed because of that. But now, I think like, 'ok, well I know what I'm dealing with.'"

**Impact of BPD Diagnosis on Attachment with Mother**

Participants were asked how their mothers' diagnosis BPD affected their ability to establish an attachment with her. Table 5 presents a summary of the results. The most significant theme that summarized participants' experiences included their difficulty in

bonding with their mothers. Key words and phrases that were coded to those emergent themes are also presented in Table 5.

Table 5

*Summary of Themes for Impact of BPD Diagnosis on Attachment with Mother*

| Axial Codes (Themes) | Open Codes (Subthemes) | Key Words and Phrases (Codes) |
|---|---|---|
| Difficult Attaching And Bonding With Mother | Hard | up-and-down relationships<br>hard for me to bond with her<br>relationship was a little more strained<br>didn't establish a true close and loving bond |
| | Strained | strained<br>strained because of her diagnosis |
| | Distant | emotionally one sided<br>very distant emotionally<br>never a heartfelt bond<br>cordial but distant<br>severed mother-daughter relationship |
| | Hurtful | hurtful and disrespectful<br>she would attack/hurt me a lot<br>negative treatment towards me<br>insulted me/ chipped away at my self-esteem |
| | Confusing | direct contradiction of her kind and loving words towards me<br>really good, the next day I can be really bad<br>mad at you for something that doesn't make any sense<br>I didn't understand |
| | Mistrust of mother | didn't trust her<br>caring about me…phony and so shallow<br>couldn't rely on her |

**Theme: Difficult Attaching And Bonding With Mother.** Several participants disclosed how they had a difficult time bonding with their mothers as a result of their mothers' illness. They recalled how attachment experiences with their mothers created interpersonal dysfunction within their mother-daughter relationships, and thus caused a

number of relationship strains. Participant 4 described her difficulty in developing a bond with her mother in the following comments:

> "It was very hard for me to bond with her. The worst of it, I would say that - I don't want to say the onset but definitely the prominence of it for me was in my adolescent years, like, 11, 12, and 13; and I understand that to be a very crucial bonding time between adolescents and their parents, especially with parents of the same gender."

Participant 6 revealed that her relationship with her mother remains unstable and unpredictable. She responded: "So our relationship is one of those up-and-down relationships. I just never know what each day will hold with her." Participant 7 explained that although her mother had a comorbid diagnosis of bipolar disorder, her ability to bond with her mother was more complicated when her mother demonstrated symptoms associated with BPD rather than behavioral features synonymous with bipolar disorder. She expounded:

> "I may be able to bond with her more when she is demonstrating bipolar disorder symptoms because with her BPD, her mood was always jacked up and messed up. With the borderline personality disorder, those sort of behaviors are what made it hard for me to bond with her."

Participant 2 explained how her mother's inability to understand how her actions impacted her made it hard for her to bond with her mother. Participant 2 shared: "She doesn't know how much I struggled with her and the things that she's done because she

won't admit that half of them even happened. She's like, you know, 'it's all made up. It's all fake.'"

Participants also reported that their ability to bond with their mothers was strained. Participant 6 best explained this sentiment with the following comments: "So my relationship with my mother is actually really strained; and like I said it's not something that she accepts and she admits." Participant 8 indicated a similar account in her response, as she disclosed: "The relationship has always been a bit strained. But then again, I knew in the back of my mind that her having BPD was partly due to this."

Some participants shared that the interpersonal challenges that they experienced with their mothers created emotional distancing between them and their mothers. Participant 10 explained during her interview:

> "Although I love my mom and I really appreciated when she was nice to me, I was very distant emotionally from her. We didn't establish a true close and loving bond because for the longest time I couldn't understand why a lot of times she treated me so horribly for no reason."

Participant 9 addressed the challenges of being in an emotionally non-reciprocating relationship with her mother, as she shared the following:

> "I learned that her love was conditional. So because for all intents and purposes I was 'the good child' more often than my siblings, I embraced our relationship as emotionally one-sided; one in which it was clear that I gained good attention from serving her codependency."

Participant 11 shared how therapists used a human interaction model to help her understand the nature of her mother-daughter attachment experiences. Understanding her mother-daughter interactions based on this social model of interaction ultimately lead her to discontinue any close connection that she had with her mother. She explained:

> "After my mother's diagnosis, while I was going to therapy, a therapist told me that I was always in what is called a Karpman Triangle with my mother. I was caught in her cycle of prosecutor, rescuer, and, um…victim! So I was basically going along with her temperament and her moods swings, and I was very catering to her needs and what it was that she wanted. I basically did not have a life. She was my life. So since learning of the diagnosis it actually severed our relationship."

Participants additionally recalled hurtful encounters that they experienced as a result of having a mother with BPD. For example, Participant 4 shared that following: "She would insult me a lot and she really chipped away at my self-esteem. So instead of me having a bonding experience in that time, I learned not to confide in her." Participant 6 recounted experiences with her mother that she recalled as unpredictable and hurtful:

> "When she's having an off day she'll just stay to herself. But when she's in a good mood, she wants to talk to you and she's ready to be right back at it and be best friends type thing; like not understanding that she had said some hurtful and disrespectful things to where you don't want to be around her no more."

Participant 1 disclosed how she questioned if her mother ever considered how their mother-daughter attachment experiences affected Participant 1's ability to bond with her.

She stated: **"**I don't know if she even factored me into the equation of us bonding, you know, after she was told of her diagnosis."

A few participants recounted the confusing nature of their relationship with their mothers. Participant 6 was reminded of her perplexing interactions with her mother. She explained during her interview: "She's mad at you for something that doesn't make any sense and you are constantly arguing over things that don't make sense. It's exhausting." Participant 5 recalled her mother demonstrated splitting behaviors associated with BPD towards her. Participant 5 shared the following: "One day you can be really good, the next day you can be really bad; and you can be the most hated person whether you are my mother's child or not. Participant 9 explained how her mother would constantly hold contradicting sentiments towards her. Participant 9 stated during her interview: "Her negative treatment towards me would be in direct contradiction of her kind and loving words towards me when she wasn't demonstrating symptoms of the disorder."

Several participants found it challenging to trust their mothers due to encounters that they had with their mothers. Participant 4 stated during her interview, "I did not trust her. I didn't trust her, I didn't identify with her. And even though I am well into my 20s, now I am approaching my late 20s, because that bond wasn't set at that time there is that wall up today." During her interview, Participant 9 recalled being scared of her mother and not trusting her during her mother's splitting behaviors. Participant 7 similarly explained that due to certain encounters with her mother where she suspected that her mother was being insincere, she was unable to view her mother as genuine. Participant 7

shared: “There was always the fact that her caring about me in any real way was so splotchy, phony and so shallow.”

**Current Relationship with Mother**

Participants were asked to describe their current relationships with their mothers. Table 6 presents a summary of the results. Emergent themes from this question included some participants believing that their relationship with their mother has improved since learning of a BPD diagnosis, while some participants reported that their relationship with their mother has distressing qualities. Several key words and phrases were coded to those emergent themes.

Table 6

*Summary of Themes for Current Relationship with Mother*

| Axial Codes (Themes) | Open Codes (Subthemes) | Key Words and Phrases (Codes) |
|---|---|---|
| Distressed | Strained | cordial but not close<br>it’s really strained/hard<br>tumultuous<br>things have gotten worse<br>separated from each other |
| Separated | Physical/Emotional Distance | moved away<br>separate from each other<br>maintain emotional and physical distance |
| Improved | Better | better now<br>love my mom<br>the relationship is a lot better |

**Theme 1: Distressed.** Several participants disclosed that their current relationships with their mothers were in some way distressed as a result of their mothers’ BPD diagnosis. Participant 4 described her current relationship with her mother as

"cordial but not close". Participant 2 noted that although she cares for her mother, the strain on her and her mother's relationship as a result of her mother's disorder causes a disconnection within their her mother-daughter attachment bond. Participant 2 stated: "I love my mom. I love her dearly. I try not to cry about it often, but she's just really not well. Our relationship is really strained. It's pretty bad."

Participant 11 shared how the negative ways in which her mother interacted with her lead her to view the relationship that she has with her mother as tumultuous. She revealed:

> "It's tumultuous. There are days where I'm always guarded because there's always the manipulation part of it. There's always the pathological lying part of her diagnosis. There's never any admittance or responsibility for anything that is said or ever done on her part. It's forever stuck in a cycle of her rhythms, her cycle, her flows and trying to keep my feet on solid ground instead of sinking into quicksand. It's not easy."

**Theme 2: Separated.** Separation from their mothers by way or physical and/or emotional distance was another major theme to emerge from data related to the participants' current relationships with their mothers. Participants recalled how creating a physical distance between them and their mothers provided as a partial solution for their distressed relationships with their mothers. For example, Participant 3 shared: "My current relationship with my mother, um, we have to be separate from each other to have a good relationship. When we're in close quarters with each other, it won't work."

Participant 2 similarly disclosed how she and her family decided to take up residency outside of the U.S. She disclosed the following during her interview:

> "Like, yeah she's very difficult. She's extremely attention seeking. I have two young children of my own and I don't have the time and attention to give her that she requires of me. I want to work on forming healthy bonds with my own children. And so, you know, I recently moved to the other side of the world to keep my distance. So many difficult moments over the past 15 years that I just, I couldn't be near her anymore. I couldn't be around her."

Participant 10 additionally shared that she maintains emotional as well as physical distance from her mother, as she stated: "I kept and still keep her at a distance from me emotionally and physically so she doesn't get to me when she acts out. I am much more relaxed when I am not in constant close quarters with her. My anxiety symptoms are not activated. I'm not as anxious."

**Theme 3: Improved.** A few participants explained how the diagnosis of BPD for their mothers helped them to understand how to better interact with their mothers as well as relate to them. They shared that as a result of the BPD diagnosis enlightening them to their mothers' mental health condition, they are currently able to have better relationships with their mothers. Such was the case for Participant 1, as she explained during her interview:

> "It's better. It's better now than before when I was in my teen years. You know, back then I was very hurt and confused and I didn't understand. During my twenties, I was reluctant to have any kind of relationship with my mom, you

> know, because of her behaviors like gaslighting and other toxic behaviors. So, back then I kept my distance. But since finding out about her diagnosis, we've actually grown closer than we have in the past."

Participant 8 described how her relationship with her mother has improved overall since learning of her mother's borderline diagnosis. She indicated during her interview:

> "I can say the relationship is a lot better, a lot stronger. I moved out of state, and I know that she took it very hard…even personally. But now, she comes to visit, I go to visit, and I just feel like there's a better handling of her symptoms. I just feel like our relationship is a lot tighter now."

**Definition of a Close Relationship**

Participants were asked to define a close relationship. A summary of these results is presented in Table 7. Significant themes that revealed that participants viewed a close relationship as a connection that fosters closeness, is pardoning, cultivating, and loyal. Key words and phrases related to the themes and subthemes are also presented in Table 7.

Table 7

*Summary of Themes for Participants' Definition of a Close Relationship*

| Axial Codes (Themes) | Open Codes (Subthemes) | Key Words and Phrases (Codes) |
|---|---|---|
| Nearness | Vulnerable | openness<br>sharing<br>honesty<br>genuineness |
| | Togetherness | becoming closer<br>shared form of intimacy<br>your inner circle<br>a partnership<br>enjoying one another's company |
| Pardoning | Accepting | allows for failures and mistakes<br>are loved for just existing, flaws and all<br>loves unconditionally |
| | Permissive | share things with you no matter how painful<br>understanding<br>reciprocating peace and understanding<br>empathy |
| Cultivating | Caring | nurturing/ motherly/ protective<br>physical, mental, emotional support<br>going through things together/ help each other |
| Loyal | Dependable | loyal/trustworthy<br>friends who have been around for years<br>somebody that you can always turn to |

**Theme 1: Nearness.** A few participants shared how elements of nearness provide as underpinning factors for close relationships, and noted how one attribute that marks a close relationship is vulnerability. Participant 1 described a close relationship as a connection that is open and provides room for all partners to make mistakes as well as receive unconditional love. Participant 6 explained that her definition of a close

relationship was shaped by the way that people outside of her family modeled healthy interpersonal interactions. She explained:

> "I knew that the relationship between me and my mother and my siblings was wrong. So whenever I would see other peoples' relationships with positive reinforcements and positive things happening and them sharing a bond, I thought to myself 'that's what life is supposed to look like, that's what's supposed to happen.' So my definition of a close relationship is somebody that you can always turn to. I feel like as long as we can talk to each other and we can communicate and be authentic and honesty with one another, we are close."

Participant 8 explained during her interview that a close relationship is a connection where all parties within the bond feel comfortable sharing personal thoughts, feelings and experiences with one another. Participant 8 explained:

> "I basically consider relationships as having connections with people in your life that are basically the family you pick. We're close. I can share things with you; my thoughts, my feelings, things that happen to me, I trust you with them."

Participants also revealed how they view close relationships as connections that encourage all individuals within that attachment to draw close to one another and support each other. For instance, Participant 4 described the following:

> "A closer relationship is one with open communication and healthy communication; communication for understanding and growth and for the purpose of becoming closer, and being supportive you know? Support- physical

> support, mental support, emotional support; and these supports are all things that I didn't experience when I was younger from my natural mother."

Participant 11 defined a close relationship as being loving connection that involves a shared form of intimacy. She stated:

> "Healthy to me can be subjective, but at the same time we have to look for parameters and boundaries about what healthy could look like and strive for that. So a close relationship to me is between two or more people that actually engage in a loving connection or a kindness or compassion and caring between each other. There is understanding and respect…a shared form of intimacy where you feel as though you are understood, and you have an understanding of the person that you seek to understand."

Participant 7 recalled how her insecure views of close relationships have evolved over the years. She shared how therapy has helped her foster a more affirmative outlook on close relationships, as she currently views close relationships as more of a partnership rather than a connection inundated with inequity, maltreatment, and adversity. Participant 7 divulged:

> "Over the last decade what defines a close relationship has really changed for me. I used to think that a close relationship is being with another person and being at their mercy. I used to think that being in a close relationship means that the other person's love or affection or whatever it is to me is based on what I'm doing. It's all about the other person; it's all about sacrificing. Everything is always about me either surrendering power, surrounding my identity, being abused, being hyper

> vigilant. Now over the years, after over like 20 years of therapy, I realize that being in a close relationship is more of a partnership and it's more about equality.

**Theme 2: Pardoning.** Another significant theme to emerge from the data included participants viewing close relationships as connections where pardoning is regularly implemented. They defined a close relationship as a bond that has trust and offers forgiveness when merited. For example, Participant 1 described a close relationship as a connection that allows for failures and mistakes. Participant 10 understood a close relationship to be endearing and forbearing as she shared the following: "A close relationship is one that is loving, caring, forgiving, and unconditional. In a close relationship, you can trust the other person with all your heart."

Participant 4 characterized a close relationship as a bond where all relationship participants make allowances for one another by accepting each other's shortcomings. Participant 9 shared her perspective of how a close relationship is largely devoid of jealously, codependency or provisional love:

> "A close relationship is a bond where there is equal trust, respect, love, true companionship, patience, protection, forgiveness and loyalty. A a close bond is truly enjoying one another's company as well as their present silence, you know what I mean? I mean, to be close to someone- a close bond doesn't have jealously, codependency, or conditional love, you know? It's like a healthy attachment; like a connection where two people are loved for just existing, flaws and all."

Participants additionally shared how close relationships allow for people to share personal experiences with one another no matter how pleasant or dismal. The following comments from Participant 8 best reflect this permissive belief:

> "I can share things with you no matter how painful. I can share good times with you. I trust you with myself, my family my friends, people I care about. My pain is your pain. Your pain is my pain. It's the same thing with joy. So that's what I consider to be close. You know everything about me. It's very open and vice versa."

Participant 9 similarly elaborated on her beliefs about permissiveness within close relationships, as she stated:" A close relationship offers reciprocating peace and understanding. A close relationship is where, like, anger is scares and forgiveness is plenty. This is why lot of times I make sure that I display the type of understanding from others that I would want."

**Theme 3: Cultivating.** Several participants found close interpersonal connections to be cultivating as they described close relationships as having caring qualities. For instance, Participant 2 drew from positive displays of mother-child interactions from others to help her shape her understanding of a close relationship. She explained:

> "You know, a close relationship has always been what I think you see on TV, or what my friends have where they talk to their moms. They tell them things that happen in their life and get appropriate feedback. They are not afraid to share and be loving and receive love. A close relationship is in a way motherly."

Participant 9 revealed how she believes that a close relationship should provide protection and an assurance of safety. She shared during her interview:

> "When you feel the protection of your partner, and believe them when they tell you that you're safe with them, you know? That they are protective of your heart, your feelings, your self-esteem, etc.; that they will not hurt you or betray you intentionally. I think that's when it's safe to say that you're in a close relationship."

Participants furthermore disclosed that close relationships should be supporting. They explained how close bonds are established when relationship participants can go through adversities and overcome challenging times together. Participant 5 held this belief, as she stated during her interview:

> "I feel like a close relationship is like somebody who's in your inner circle that might know the good things and the bad things about you. You have a shared victory. You've going through things together."

Participant 10 shared a similar view, as she stated that people involved in close relationships should be helpful rather than demonstrate maliciousness towards their partners. Participant 10 explained: "You help each other and want to see each other at their best and not tear them down to their worst. I can imagine that is what healthy relationships are supposed to be like."

**Theme 4: Loyal.** The fourth theme to emerge from this enquiry was loyalty. Some participants explained that loyalty was an essential element within a close relationship. They noted that dependability provided as an indispensable characteristic

for a close relationship. For instance, Participant 3 stated during her interview that loyalty and reliability were underlining components of a close relationship. Participant 5 explained how an extensive relationship history and the shared experiences that accompany this lengthy connection signify loyalty and dependability within her close relationships. She provided the following comments:

> "A lot of my friends who I'm close with, we've gone through things together, which is why I allowed them in closer. I believe you can make a friend at any age. You just become close. But for me it's kind of like the friends who have been around for years, who have seen firsthand, who have known the stories, who have lived through it. Those are the close ones that I let know everything. And even though they complain that I don't let them in enough or I only let them in to an extent, they are the closets to me. So yeah, basically for me longevity is attached to close relationships."

**Impact on Current Ability to Form Attachments**

Participants were asked to explain how their attachment experiences with their mothers influenced their current ability to form close relationships with others. A summary of these results is presented in Table 8. Significant themes that summarized participants' experiences included their difficulty attaching and bonding with others, intrapersonal difficulties, interpersonal insecurities, and encouraged their desires to establish healthy relationships. Several key words and phrases were coded to those emergent themes.

Table 8

*Summary of Themes for Impact on Current Ability to Form Attachments*

| Axial Codes (Themes) | Open Codes (Subthemes) | Key Words and Phrases (Codes) |
|---|---|---|
| Difficulty Attaching And Bonding With Others | Trust issues | difficulty connecting/sharing with others<br>learned not to trust other women/suspicious of women<br>foundation of trust wasn't laid<br>careful about relationships |
| | Insecure attachments | difficult to form healthy relationships/I'm a loner<br>have others around just so I wouldn't be alone<br>unhealthy relationships feels natural<br>attachment style is insecure<br>more comfortable having casual friendships<br>weary of forming new relationships<br>someone will only like or love me if I make them happy<br>mom with BPD influenced my ability to make friends<br>internalize/don't feel comfortable expressing feelings<br>feel I'm disposable and I don't have any real value<br>don't know how to be the mom I want to be<br>always wonder what does this person want from me<br>hard time really believing someone loves me |
| Compromised Interpersonal Relationship Attributes | Maladaptive interpersonal schemas | close relationship…people will try to smother me<br>fear of being like my mother<br>do people really like me |
| | Fear of codependency | codependent tendencies in my relationships<br>always need somebody in my life<br>can't stand you, but I need you |
| Encouraged Desire For Healthy Attachments | Incited hope | work on relationship with my family everyday<br>eager to form attachments with other women<br>desire to completely trust people I care about<br>still believe that there are awesome guys out |
| | Encouraged positive behaviors and pursuits | try to emulate other mothers who I've learned from/kind/personable<br>doing my own healing work<br>psychiatrists/therapists said I'm an anomaly and<br>negative relationship cycle breaker<br>tearing down the walls that I've built up<br>still learning and working on that<br>okay in regards to friendships |

**Theme 1: Difficulty Attaching And Bonding With Others.** The first theme to emerge from this enquiry was participants have a difficult time with attachment and bonding with others as result of their attachment experiences with their mothers. Participant 10 expounded her experiences with her mother affected her ability to trust:

> " Since I didn't have a close bond with my mother, more particularly when I hit my teenage years, I learned not to trust other women; not to have women as close friends because they may flip on you or stab you in the back. I know it's not true now, but since I found out about my mom's diagnosis a little later in life, I already formed relationship patterns that include me not getting close or hanging out really with other women."

Participant 5 explained how having a mother with BPD discouraged her outlook and patience for close female attachments. She shared during her interview:

> "I have to say that because of my mother, I do have a lower patience with women. And I hate to sound like a stereotype, but it's kind of like how women don't get along sometimes. I kind of get suspicious of them, you know? Like, I have a few close female friends but it's like I even kind of keep them at arm's length. I don't let them get too close."

Participant 11 similarly shared that she exercises caution when forming new relationships due to her poor attachment history with her mother. She explained:

> "I am careful about relationships because every person that I've actually allowed into my life whether it's been with me trying to form friendships, or to create

> some kind of sisterhood, or even romantic relationships have all been dysfunctional and had abuse."

Some participants expressed how bonding experiences with their mothers negatively impacted their ability to pursue, form, and establish secure attachments with others. Participant 1 relayed this point as she revealed the following during her interview: "It's difficult to form healthy relationships. It's something that I have to work at." Participant 5 elaborated on how her attachment experiences with her mother conditioned her to believe that interpersonal challenges have to accompany the pursuit of forming and establishing intimate connections with others. Participant 5 explained the following:

> "Well, it's hard to let people in because it's like when you're raised by a mother with BPD you knew or you always felt that love went to an extent. Like, it wasn't unconditional…you feel like love is not long lasting. I always felt like you had to chase love to have love instead of somebody just giving it to you. It doesn't feel right or it freaks you out when it's healthy. So yeah, you feel like you have to be in a situation where you have to fight for it or you have to, like, have somebody ignore you to make you, like, beg for love or that kind of thing. So pursuing love where a challenge is required feels natural. It makes you really anxious. It makes you- it makes you never really comfortable. It makes you comfortable with being uncomfortable if that makes sense."

Participant 6 revealed how her relationship with her mother affected some of her past unhealthy relationships, as she shared the following during her interview:

> "At times, I wasn't in the best or the healthiest of relationships. And as I'm getting older I'm realizing that in those relationships in the past, I would just have anybody around for however long because I didn't want to be alone; and I know I picked up these views from the way that my mother treated me. I saw that you can have a codependent relationship with someone who is also abusive."

Participant 10 explained how she has a challenging time establishing intimate connections with romantic partners. She shared:

> "So with men I'm more comfortable having casual friendships with them. But if I'm dating them, still, intimacy is not really required in our connection. Like, to be close, and I guess, attached to a man, that's still a lot for me. To say 'I love, you', I don't think I've ever gotten that far, or at least meant it because I'm not really sure what that means. Like, what I am supposed to feel other than butterflies in my stomach, you know?"

Participant 7 similarly explained how she categorizes her attachment style as insecure. She explained how intimacy within her relationships remains difficult to obtain. She disclosed during her interview:

> "My attachment style with women is different from my attachment style to men. With women, forget about it. With women it takes so much work for me to trust other women, for me to know how to engage with other women, and all around for me just how to interact with other women. So it's the women piece that's really painful. My attachment style is very insecure. It's definitely insecure. It takes a long time for me to feel safe on the inside. You know on the outside I'm

> very warm and bubbly and I do have a thin layer of trust and what not. But that real intimacy stuff, forget about it."

Participants 8 described how the insecure attachment and disconcerting experiences that she initially experienced with her mother created hesitations with bonding within her attachment practices. She shared how she is generally apprehensive when forming new relationships, and how establishing close bonds with others is not generally a priority for her. Participant 8 disclosed:

> "I am not looking to meet people right away. I think that my mother having BPD has actually influenced my ability to go out, and like, make friends with people honestly. It's like I don't want to risk bringing someone into my family and having them see something at home where they will question what is going on, nor do I want to end up getting into a close relationship with someone who has similar behavioral disturbances as my mom."

Some participants shared that they struggle with insecurities associated with attaching and bonding with others. These anxieties include participants feeling insecure about the bonds that they aim to create with their own children. Participant 2 explained how she struggles with her relationship with her daughter as a result of the insecurely attached relationship that she had with her mother. She reveled:

> "I think the biggest difficulty is the relationship with my daughter because I don't know how to be- I don't know how to be the mom that I want to be because I've never had one' even though I had a mom…I just feel like I fail: and, it's not for lack of love. I love my daughter and she loves me. I just don't know how to be a

> mother to a teenager. I don't know how to help her become a strong independent woman. I don't know how to help her have confidence in herself because my mother never taught me any of that. That was never something that was part of our discussions or our lives."

Some participants also expressed feeling uncertain about being valued or being worthy of receiving love in their friendships. Participant 7 explained how the challenging relationship that she had with her mother damaged her self-esteem as it pertains to friendships. She revealed that she has a difficult time believing that she brings any value to her friendships in the following response:

> "My mother raised me to believe not to trust anyone, particularly women; and she has verbally told me such. And not only did she tell me this, she did this in my life. Any close relationships that I had with women that I had in my life she made sure that she ripped them away from me, or she destroyed my relationships somehow. Because of this, I've always looked at myself as disposable. I usually go into the relationship believing that I'm not a factor and that I'm disposable and I don't have any real value. That's kind of how I've always went into any relationship; romantically or otherwise."

Participant 10 explained how although she has a desire to have intimate connections, being a recluse provides as a protective approach to avoiding painful relationship experiences. She explained how she has a difficult time believing others when they express intimate feelings and emotions towards her. Participant 10 provided the following response:

> "I'm kind of a loner. Sometimes I like it because I feel like that's the best way to protect myself from others hurting me. But sometimes I resent it because I really want to feel loved and accepted for who I am. So, even if someone really loves me for who I am I have a hard time really believing that they do."

**Theme 2: Compromised Interpersonal Relationship Attributes.** Another significant theme to emerge from this question revealed that participants had developed compromised interpersonal attributes such as maladaptive interpersonal schemas a result of attachment experiences related to having a mother with BPD. For example, Participant 10 admitted that when she thinks that someone is trying to establish an attachment with her, she tends to believe that they will try to "smother" her. Participants also expressed their beliefs that the codependency issues that they struggle with in present day are as a result of their negative mother-daughter interactions. Thus, this relationship insecurity has led participants to be cautious in forming attachments with others. Participant 10 explained how she questions whether her mother's codependent behaviors affected her own attachment and bonding experiences. She explained the following:

> "I also fear that I may even have codependent tendencies with my relationships because of my encounters with my mom, I don't know. But if my codependent issues are linked to my relationship with my mom, they may not be as obvious as hers."

Participant 9 shared how her insecure attachment patterns with men typically coincide with codependent behaviors. She relayed this belief during her interview:

> "Even though I don't fully trust men, in some ways I rely on them way too much for validation, and it drives me crazy! It drives me crazy because I kind of feel like I'm sending them mixed signals, like, 'I can't stand you, but I need you, and don't leave me!' You know?"

Participant 6 explained how her relationship with her mother shaped her own relationship codependent behaviors. Participant 6 indicated the following: "So, I think for me with experiencing my mother's ups and downs, I feel like I always need somebody in my life. I need consistency. I feel like that's what I need. Yeah, and I need consistency all the time.

**Theme 3: Encouraged Desire For Healthy Attachments.** Participants additionally expressed having an overall desire to form healthy attachments and connections with others. Participants shared how despite the difficult bonding experiences that they had with their mothers, they remain hopeful for future healthy attachments within relationship. Some participants reported how they desired to be more trusting of others. Participant 9 expressed this sentiment appropriately as she explained: "I do have a desire to completely trust people I care about." Participant 4 communicated a hopeful stance on forming healthy attachments as she explained how her relationship with her mother encouraged her to pursue close bonds with older women. Participant 4 explained:

> "I would have to say that I am very eager to form attachments with other women; especially older women because I never had that with my natural mother. I encounter a lot of women who are a lot of different ages, so I'm very open to

> having a close intimate relationship with women that are a little bit older than me to kind of, you know, replace that relationship that I should have had with my mother."

Similarly, Participant 10 indicated that although she currently holds apprehensive views on attachments and intimate bonds, she has the understanding that healthy attachments can be formed. Participant 10 revealed: "I know there are great women out there who are kind. I also still believe that there are awesome guys out there that won't play you."

Some participants reported on how their negative attachment experiences with their mothers inspired them to desire to seek and establish healthy connections. For example, Participant 2 expressed that her chaotic relationship with her mother inspired her to observe how healthy mother-daughter bonds were demonstrated through those between her friends and their mothers. She indicated during her interview:

> "I had a mom who was a shadow of the person that should have and maybe could have been here. She was like a stand in. So I try to emulate these other mothers who I've learned from, and who I love."

**Insights Gained about Mental Illness**

Participants were asked how their experiences of having a mother with BPD affected their knowledge and understanding of mental health. Some participants reported that having a mother with BPD gave them insights into the struggles that people with mental health problems endure. Participants shared that their mother-daughter interpersonal experiences encouraged them to examine how mental health issues pervasively impact their own families. They also disclosed how dismissive attitudes

towards mental illness as well as inflexible social ideologies about Black women remain concerning aspects of mental health awareness within the African American community. Table 9 presents a summary of the major themes, subthemes, and codes for this question. Several key words and phrases were coded to the emergent themes.

Table 9

*Summary of Themes for Insights Gained about Mental Illness*

| Axial Codes (Themes) | Open Codes (Subthemes) | Key Words and Phrases (Codes) |
|---|---|---|
| Consideration For Those With Mental Illness | More understanding | made me realize what the real issues are<br>have a greater respect for it/ more patience<br>have to deal with it<br>more understanding/considerate for Black people who struggle with mental illness |
| | Mental health of African American women | mental health is a very real/Back women not crazy<br>mental health, deal with on a personal basis<br>important to address mental health in the African American community<br>importance of/ passionate about mental health for Black women<br>need more mental health intervention specifically for Black women |
| Knowledge | More education | become more educated on topic/study up on BPD to understand mom<br>considered going into psychiatric nursing/want to be clinical therapist<br>mental health is what I want to study/want degree in psychology<br>have my Master's in psychology |
| | Need from more research | need for more rhetoric on Black psychology<br>Black women underrepresented in mental health research<br>scarcity in research on Black and African American mental health<br>need more statistics on Black mental health |
| Transgenerational Nature Of Mental Illness | Impact of parental mental illness | psychiatrist suggested my daughter has borderline traits<br>I got diagnosed with BPD myself/struggle with depression/anxiety<br>triggered by my mother<br>impacts generations/mother has mental issues so the children have it<br>my brother and his negative behavior believes this is normal behavior |
| Trivializing Attitudes Towards Mental Illness | Dismissive | Black community, we just write people off as they're crazy<br>negative language related to mental health<br>African-Americans, we're not big on mental health<br>Black families-make fun of me for going to therapy<br>stories surround abuse towards Black girls are laughed at<br>our culture tends to deny issues concerning mental illness |
| Social Ideologies About Black Women | Strong Black woman archetype | not supposed to be strong Black woman without issues<br>strong Black women…groomed to be martyrs<br>strong Black superwoman is not engaging in self-care |

**Theme 1: Consideration For Those With Mental Illness.** Participants explained how they developed a positive regard for their mothers because of their challenging mental health condition, and encouraged them to have the same consideration for others who struggle with mental illness. For example, Participant 4 explained how having a relationship with her mother who struggles with a personality disorder allowed her to observe mental illness as it pertains to Black people.

> "When I found out that my mother was not just crazy or mean, that she was actually mentally ill, it-it shocked me because I was never really given education that I could recollect or retrieve explanations from that could explain my mother's behavior. So just seeing Black psychology and Black mental health struggles up close and personal, it was very eye-opening you know?"

Participant 5 explained how having a mother with BPD made her realize how imperative mental wellness is and how neglecting mental health issues can lead to unfavorable life outcomes. Participant 5 disclosed the following:

> "It's made me realize what the real issues are. A lot of the times people want to think it's fake. They think mental illness is an excuse, or people say they're just kind of off; they're just this and they're just that. No. In reality mental health is a very real and valid thing that if people don't take care of, it can really hurt you in the long run."

Numerous participants divulged how their experiences with their mothers caused them to have a more serious outlook on mental health and wellness; more especially as it pertains to Black women and the African American community. They provided accounts

of how their experiences with their mothers brought them to a realization that Black women can have serious mental health problems like any other people. Furthermore, experiences related to having a mother with BPD provided participants with an outlook that encourages more understanding of issues that affect Black female mental health. For instance, Participant 10 admitted: "I am much more understanding of the importance of mental health, especially for Black women." Participant 4 similarly shared how her experiences with her mother caused her to arrive to the conclusion that her mother was not "crazy"; rather more than likely developed faulty coping mechanism that helped her navigate through adverse life experiences and consequently may have influenced her interpersonal relationship abilities.

> "Black women especially, they're not crazy. You know, they may have experiences in their lives that could possibly cause them to make defense mechanisms and coping mechanisms that may have helped them survive, yet ultimately hurt their loved ones. And like I said even though being at the receiving end of it isn't pleasant, it gives you more of an understanding and more of a patience for them."

Participants also shared how having a mother with the mental illness of BPD enlightened them to look beyond dysfunctional behaviors and stereotypes in order to acknowledge possible mental, behavioral and emotional issues. Participant 6 explained how her experiences with her mother caused her to consider her mother's mental health condition when processing her encounters with her mother rather than labeling her

mother with a popular social archetype for Black women. Participant 6 revealed the following:

> "It has opened my eyes, my mind and all of that too. I'm taking mental health so seriously now. Everyday I have to remind myself and my boyfriend helps remind me everyday that my mother has a mental illness called borderline personality disorder. So that means she not just an angry Black woman. She's not a crazy or ghetto Black woman or insane, even if she acts that way."

Participant 7 recalled how witnessing her mother's mental health struggles inspired her to consider the importance of paying attention to mental health, and how the lack thereof can adversely affect one's life. She reported:

> "Throughout my experiences I have definitely seen the importance of paying attention to one's mental health because there have been times where I have seen my mother have mental breakdowns. So I've seen the impact of neglecting one's mental health and how an untreated illnesses can definitely run rampant in someone's life."

Additionally, Participant 10 emphasized the necessity for mental health interventions for Black women. She noted: "There needs to be more mental health intervention that caters specifically to Black women."

**Theme 2: Knowledge.** Knowledge acquisition was another significant theme to emerge from this enquiry. Participants shared that they aimed to fortify their understanding of mental health through academic education and pursuing professional careers in the field mental health as a result of having a mother with BPD. For instance,

Participant 1 shared: “I've done more research on BPD and mental health. I've even taken more classes to understand more.” Participant 2 explained how her relationship with her mother motivated her to consider pursing a career as a psychiatric nurse. She stated:

> “I started looking into caring in the form of mental health type of classes and courses early on in school. Like, my very first university class was Psych 101 followed by Abnormal Psych. I had just found it absolutely interesting. I then considered going into psychiatric nursing, and then going into psychology. I have always been a psychology major because of my childhood experiences.

Participant 6 described feeling hopeful about her future academic pursuits that were inspired by her mother’s mental health condition. She revealed: “At the same time I kind of find it kind of exciting because I’m starting college soon and I think mental health is what I want to study.”

Several participants disclosed how having a mother with BPD made them more aware of a need for more research on mental illness in African Americans. Participant 4 addressed this belief in her response as well as how she believes that Black psychology is still recognized within academic institutions as an emerging discipline. She stated:

> “I don’t have too many references to Black psychology and understanding it, even though I was in college just a few years ago! In fact it wasn’t until my later years of college where there was some buzzing of the need for more rhetoric on Black psychology.”

Participant 9 similarly shared her belief on that mental health issues that chronically affect Black people are largely attributed to the scarcity of attention to Black mental health issues within psychological literature. She shared during her interview: "Black people have endured so much since really the beginning of time; and yet there is such a scarcity in research on Black and African American mental health, with mental health issues being what I believe to be the root of our past and present issues." Participant 10 also communicated her belief that there remains a need for more research on mental health in Black people. Participant 10 disclosed:

> "After seeing my mom suffer through poverty and now what I know to be mental illness, I believe that there needs to be more statistics on Black mental health. There has to be more references and studies that support people like my mom, like us!"

**Theme 3: Transgenerational Nature Of Mental Illness.** Another significant theme to emerge from this query was participants becoming more aware of the transgenerational nature of mental illness. They shared how their relationships with their mothers made them more understanding of how mental illness can have a considerable impact on family mental health. Most notably, Participant 11 explained how her mother-daughter attachment experiences enlightened her to the impact of BPD as well as the affect that the disorder has had on her family. She stated:

> "My experiences affected my outlook on mental health exponentially. I now understand how mental illness affects families beyond the family member who's ill, you know? Because for my family, it's not just my mother that has it; it's my

> grandmother and other family members that have it. It affects more than just me, more than just my mom. The impact of this disorder comes through generations."

During Participant 7's interview she shared that she suffers from BPD herself, and shared how she "sees a lot of parallels" in how her and her mother demonstrate behaviors associated with the disorder. Participant 3 also communicated this understanding of transgenerational mental illness in the following response:

> "Unfortunately my older sister came out with a disorder too. And then my younger sister had a disorder; and my grandmother told me she thinks it's because my mother has mental issues, so the children have it. So, I try to be aware of how mental illness affects families, even for my kids."

Participant 2 explained how her teenage daughter currently demonstrates symptoms of BPD, which makes it difficult for her and her daughter to bond. She shared during her interview:

> "So, even my teenage daughter, she's really struggling. She is. She's literally my mother and it is, um… I am committed to doing everything I can so that my daughter can have a healthy life. But the psychiatrist overall suggested that my daughter has very borderline personality traits, you know?"

Participant 6 told of how she believes her mother's mental illness of BPD shaped her brother's present day behaviors and temperament. According to Participant 6, her brother has a difficult time demonstrating caring and empathetic behaviors. She explained: "My brother with his negative behavior believes that his bad behaviors are normal behaviors. Like, my brother does not care about anyone else's feelings at all."

**Theme 4: Trivializing Attitudes Towards Mental Illness.** The final theme to emerge from this enquiry was participants disclosed how having a mother with BPD brought them to awareness about how trivializing attitudes towards mental health still persist within the African American community. They explained how having a mother with BPD gave them insight into how a mental illness like BPD can influence attitudes and outlooks towards mental health in the Black community. This inference is reflected in Participant 5's response where she explained: "Your mental health can really make or break you. The most painful part is unfortunately with African Americans, we're not big on mental health even if a mental health crisis is happening right in front of us." Participant 4 shared how she believed that Black communities continue to neglect prioritizing mental health in comparison to other demographics. She stated:

> "I feel like in non-Black communities and non-ethnic communities, mental health is highlighted and you know what it looks like through all areas of the spectrum. But in the Black community, we just write people off as they're crazy, their ghetto, they're 'insert any dismissive adjective here' you know? Honestly, anything but 'hey, they may be struggling with a mental illness."

Participant 6 shared how her cousin's death caused her to reflect on how Black people neglect and negatively handle mental illness and dismiss symptoms associated with mental illness. She highlighted how dismissiveness of mental health wellness within the Black community may lead Black people to adopt negative coping mechanism. Participant 6 revealed:

> "In terms of my family, mental health is just not talked about. We have a lot of animosity and anger. Even in my family right now, a lot of them who either know or don't know that my mother has borderline personality disorder, they just hate her you know? They say things like, 'we don't like her; we don't get along with her.' And like, my cousin passed away from suicide and my family wants to play it as if he was messing around with the gun and the gun went off. Like, no no no! We know what really happened with my cousin! We know what he was fighting! We know what he was going through! But people wanted to turn a blind eye to it and not address it and write it off as that's just what Black people do."

Participant 11 commented on the indifference that she observes when listening to relationship experiences that Black women endured during their childhood. She relayed her frustrations about attitudes of amusement expressed towards negative family relationship experiences influenced by mental illness. Rather, Participant 11 explained that she would like to Black women to reflect on if their experiences where actually positive or negative. She explained:

> "Having a mother with BPD alters so much of your perception and your experiences, and I think that needs to be screamed. We need to wake up. A lot of the stories that we tell as Black women growing up, we laugh at them. I used to cringe with the things my mother would say about my grandmother and the things that my grandmother would say about my mother and my aunts. I now realize that all those interactions were abusive. So I want Black women to stop laughing at those things and really think about if this type of abnormal behavior is ok.

> Think about how those experiences truly make me feel. If they doesn't feel good then something is wrong."

**Theme 5: Social Ideologies About Black Women.** A few participants expressed their disdain towards the SBW social schema. They explained how this social ideology conditions African American women to neglect mental and emotional wellness and persuades Black women to suppress their discomforts. For instance, Participant 4 shared her beliefs about the SBW myth: "Black women are not supposed to be strong Black woman that never have any issues."

Participant 10 also acknowledged the SBW ideology. She explained how the SBW conceptual ideology could negatively affect the ability for Black women to relay their struggles to others, and thus cause them to internalize their distress. She stated:

> "We seriously need to stop conditioning Black women to be in relationships where a struggle is normal; or that we have to be like strong Black woman all the time. I actually really don't like that "strong Black woman" label to be honest because so often, we are groomed to be martyrs, you know? Martyrs for our families, martyrs for our men and relationships, martyrs for our community; and all the while we are literally dying inside, screaming for help. But it's like no one wants to listen. No one wants to see us beyond our stereotypes, and it really stinks."

Participant 11 shared her belief on how the SBW stereotype impacts self-care in Black women:

> "To me, the strong Black woman is not engaging in self-care. She is neglecting taking care of herself because she's so busy taking care of everyone else you know? It make's me think, 'well, what about you sis? How is your mental and emotional health? Do you need to see a therapist or a mental health professional?' We weren't designed to carry the weight of the world by ourselves."

**Further Information about Having a Mother with BPD**

Participants were asked if there was any additional information they would like to share with others pertaining to how having a mother diagnosed with BPD affects a person's outlook on relationships. Table 10 presents a summary of the results. Emergent themes from this question included relational challenges, intervention and support, consideration, hope for healthy attachments, and intrapersonal healing. Table 10 presents a summary of the major themes, subthemes, and codes for this question. Several key words and phrases were coded to the emergent themes.

Table 10

*Summary of Themes for Further Information about Having a Mother with BPD*

| Axial Codes (Themes) | Open Codes (Subthemes) | Key Words and Phrases (Codes) |
|---|---|---|
| Interpersonal Challenges | Relationship shortfalls | still trying to figure relationships out<br>going to be hard<br>coming from this type of mother-daughter relationship need help |
| | Intrapersonal struggles | can really degrade your self-identity<br>lead people into very unhealthy coping mechanisms<br>we have relationship and mental and self-esteem problems too<br>negative relationship cycles will consume you |
| | Insecure bonding | behind the eight ball in making the most out of my relationship with her<br>you can attract a lot of dysfunction into your life<br>we can really have a lot of difficulties when we grow older<br>didn't really learn to trust people right away |
| Intervention And Support | Need a support system | challenging without a support system<br>joined these support groups<br>Facebook support group for people with family with BPD<br>channel of support that is open when you can open up |
| | Therapy | have therapy in some way be a part of your healing work<br>started therapy/ therapy for years<br>therapy teaches you to maintain integrity |
| Consideration | Sympathy for mentally ill loved ones | accept them for who they are<br>it's not their fault that they're like this<br>try not to get upset with things attributed to her diagnosis<br>understand there's a side of mother that loves you |
| | Patience | learn patience<br>you have to be forgiving/ let things go more<br>love freely, even your mother |
| Hope For Healthy Attachments | Forming attachments and bonds with others | look for the help<br>ok to let someone in/connect with others/you can desire and form healthy relationships<br>there is a way out/there is hope<br>ok to let someone in/connect with others<br>to try to build intimacy and closeness |
| Intrapersonal Healing | Self-restoration | not to internalize things/ unpack your issues<br>maintain self-identity/mental health<br>lose that identity that people try to stick to you<br>be careful of becoming more withdrawn |
| | Positive personal outlooks | your mother's illness in not your own<br>other relationships won't be the same as with your mom<br>don't let your experiences impact bonding with other people |

**Theme 1: Interpersonal Challenges**. A significant theme to emerge from this enquiry included the interpersonal challenges that participants experienced as a result of

having a mother with BPD. They explained how having a mother with BPD could cause daughters to develop relationship shortfalls and intrapersonal struggles, and in turn hinder their ability to establish secure attachment patterns. Some participants revealed that they had various relationship challenges as a result of the tumultuous relationship experiences that they shared with their mothers. For example, Participant 11 explained how having a mother with BPD could influence the type of relationship dynamics that adult daughters participate in. She commented: "Having a mother with this disorder in a way skews who you attract. You can attract a lot of dysfunction and dysfunctional relationships into your life." Participant 6 disclosed how being a daughter of a mother with BPD is difficult, and such girls and women will require help and support from others. She stated:

> "I want people to know that it's kind of scary to be raised by a parent who has a mental illness; and then be raised with a parent who has mental illness and knows they have an illness and who does not want to get help. People who are coming from this type of relationship with their mother, we are also going to need help from our partners, our friends, our families, our therapists."

Participant 2 indicated that she continues to pursue an understanding of how to form meaningful close attachments. She shared:

> "I'm only in my early thirties; I'm still trying to figure close relationships out. I feel like I'm so behind the eight ball in making the most out of my relationship with her my mother, my relationship with my daughter and my husband and sometimes others"

Participants also shared how their mother-daughter experiences affected their self-esteem. Such was the case for Participant 4, who explained how having a mother with BPD could negatively impact a daughter's selfhood. She reveled**:**

> "So, I would say dealing with a mother who has borderline personality disorder and treats you according to relational symptoms of this disorder can really degrade your self-identity. Your self-esteem can really be damaged if you don't learn to form a healthy and loving view of yourself."

Participant 10 claimed that people should know that African American women also encounter challenges related to mental health. She explained how African American women who struggle with mental health issues should not be dismissed or stereotyped. She provided the following comment:

> "As an African American woman, I want others to know that we have relationship and mental and self-esteem problems too. We have mental illness in our families too. This doesn't make us crazy, ghetto, or habitually angry. We are walking around with unaddressed social and psychological issues that other races have more of a luxury of properly addressing. So, if we come off as mean or angry or argumentative or whatever, it's not because we were born that way or it's a Black woman thing."

**Theme 2: Intervention And Support.** Another significant theme to emerge from this question was participants' endorsement of various forms of support systems and therapeutic interventions. Participants shared how community support through family, online and social media groups and therapy can provided as helpful avenues for sharing

experiences associated with loved ones who have BPD, and support pursuits for individual healing and personal growth. For example, Participant 6 shared that although she is not currently seeing a therapist, BPD online and social media support groups have connected her with other adult children who have loved ones who have BPD. She explained that she has found these groups to be helpful as she indicated the following:

> "Currently I'm not speaking to a therapist or anything right now but I really want to. Even talking to you right now is helpful. And luckily for me I found the borderline personality disorder Facebook support group for people who have family members with BPD including other social media groups that support the same thing."

Participant 8 shared how she appreciates the support that she receives from her loved ones in regards to understanding the relationship dynamic that she has with her mother. She stated:

> "People who are in your life will love you, even if they know something is wrong. It's not going to make them run away from you or change their perception of you. And it actually helps too because there is another channel of support that's open when you can open up to your loved ones. They can be kind, understanding and considerate towards you, and even your mom."

Alternatively, Participant 1 addressed how a lack of a support system can have negative experiential consequences as she disclosed the following:

> "Having a mother with BPD is, um, it can be challenging. I guess it can be especially challenging if you don't have a larger support system with like siblings

> or you know, a father, or, you're not close with any other extended family. It can make life really hard for you."

Therapy was another supportive intervention endorsed by participants for dealing with issues related to having a mother with BPD. Participants attested to the impact that therapy can provide, including unburdening one's mind and supporting one's overall wellness. For instance, Participant 7 explained:

> "There is a way out of the consequences of being raised by a mother with borderline personality disorder. One potential way out is through therapy. It may not be the only way to deal with stuff, but therapy is a great way to work through and unpack your issues."

Participant 9 echoed similar sentiments, as she disclosed the following:

> "I believe faith and the proper therapeutic interventions can absolutely make a significant difference. Make sure that your mental, emotional and physical health is well maintained first; then, you do the best you can with others. Also, it's ok to have therapy in some way be a part of your healing work. In fact, I would almost say you need to have some sort of therapy outlet to help you sort through your issues and even help you grow."

Participant 11 disclosed how therapy could help someone understand their experiences and teach them how to maintain personal integrity when interacting with someone who has BPD. She stated:

> "Going to therapy will allow you to ask more questions so you can bring more of these issues to light. It will also teach you how to still maintain a sense of

integrity in terms of what you're dealing with the person that has been diagnosed or undiagnosed with the disorder."

**Theme 3: Consideration.** Another major theme to emerge from the data was the consideration that participants had for their mothers. Participants explained that although having a mother with BPD can create challenging attachment experiences, there is an underlining understanding that being considerate towards their mothers contributed to their experiences. They explained that employing sympathy towards their mothers as a form of consideration encouraged them to holistically understand how the onset of BPD likely lead to behavioral precursors that influenced their mothers' faulty interpersonal skills. For example, Participant 9 expressed:

> "My mother is not her illness. When you learn that BPD is more than anything caused by traumatic events involving abuse and/or neglect during childhood, you come to understand that there is an inherent side of your mother that really does love you."

Participant 1 indicated that although African American daughters who have mothers with BPD can view their mother as flawed, they can still acknowledge their mothers as worthy of love and acceptance like any other person. She emphasized: "Try to love them in spite of their illness. Just accept them for who they are with the personality disorder and all. I mean, no one's perfect." Participant 3 also suggested exercising patience and understanding for mothers with this disorder as she asserted: "Learn to be patient with them because it's not their fault that they're like this."

A couple of participants explained that having a mother with BPD could cultivate patience and understanding in adult daughters, and can even lead to a restored bond between mother and daughter. Participant 5's response best reflected this code, as she noted how having a mother with BPD could teach daughters to be forgiving towards their mothers. She explained: "It's like you have to be forgiving. It really teaches you to forgive. You have to forgive or else you're going to be really mad about some issues."

**Theme 4: Hope For Healthy Attachments.** Another theme to emerge was participants having a hope for forming healthy attachments and bonds with others. In spite of the challenges that participants have had to endure, a significant amount of participants endorsed learning to trust others and encouraged the pursuit of healthy relationships. This was best reflected in Participant 9's response where she explained that there is hope for forming healthy relationships: "We may have some problems and issues like anybody else, but the reality is we can be in healthy, loving relationships with anyone we choose too." Participant 8 stressed the importance of building trusting bonds and forming connections. She explained how even if someone has a trepidatious disposition towards building trusting relationships, abstaining from learning to trust others could lead to missed opportunities to form healthy attachments. Participant 8 stated:

> "If you let your relationship with your mom affect how you relate to other people, what happens is that you can start thinking, 'what if I run into someone else that has this disorder? How will I deal with this?' Those thought patterns and perceptions will stunt your ability to meet new people and grow and make

> relationships. I just want everyone to know that that should not happen. Just try your very best in connecting with others. You can learn to trust other people and have safe and positive relationships and attachments."

Participant 5 recalled how her negative relationship experiences with her mother encouraged her to seek and receive compassion and understanding from people who cared about her. She communicated that even though she grew up being associated with painful stigmas that accompany having a mentally ill mother, she endorses the formation of trusting connections and bonds. She commented:

> "I would tell everybody that it's ok to make a friend. It's ok to let someone in. It's ok to let someone know that that is your background and history. Like, I used to be afraid every time I had a new boyfriend that was trying to meet her, or like if she would do something, I was afraid that we would have to have that conversation, and it's a scary conversation. But if somebody is really meant to be with you and they really love you and they care about you, they would understand and they would not hold your relationship history against you."

Similarly, Participant 10 categorically maintained that African American women who have mothers with BPD "desire to be mentally free and laugh and have long lasting intimate friendships and relationships like anyone else."

**Theme 5: Intrapersonal Healing**. The final theme to emerge from this question was the surety that intrapersonal healing is possible for African American women who have mothers with BPD. Participants asserted that although experiences related to having a mother with BPD can adversely affect a daughter's self-esteem, there is hope that

personal esteem and identity can be repaired. For instance, Participant 4 shared this hopeful sentiment in her response:

> "It took a lot of years of personal growth and encouragement from outside support systems for me to be the independent, well-to-do, highly self-esteemed young lady I am today. I want people to know that your self-identity, it can be restored. You can be cognizant of how your actions affect others as well as yourself. You can possess and demonstrate emotional control, even though your mother didn't teach you this. You can be confident and disciplined."

Participant 5 shared that it is important for her to have an intrapersonal consciousness that encourages her to be mindful of her actions. She explained that this form of self-reflection enables her to consider if her behaviors or actions are similar to BPD characteristics demonstrated by mother. She additionally explained that the stigma of having a mother with a mental illness does not have to accompany a daughter's budding self-identity. Participant 5 emphasized the following:

> "It teaches you to be a little more humble as funny as it sounds. This is because my mother's treatment towards me made me a different person in the world where I'm not, like, cocky or arrogant. I don't have a narcissistic personality like she does. I actually thought about it lately that I don't want to be her. So I have to take a step back and make sure I'm not. And if you find that you are becoming like your mother, remember that you can change and you can lose that identity that people try to stick to you."

Participants additionally shared that having a positive personal outlook on mental health and interpersonal connections is possible for daughters who have mothers with BPD. They shared how having a mother with the disorder does not mean that adult daughters have to shape their identities based on negative attachment and bonding experiences that they had with their mothers. Participant 9's response accurately captured this point of view:

> "I have a lot of attachment and bonding issues that I need to definitely work through; but I also am aware of the fact that I have the power to define my identity. Since I pretty much know right from wrong and how to treat others, and I understand that I have the power to relate to other people in a positive way, I understand that I am not my mother's illness."

Participant 1 similarly asserted this idea, as she explained how future relationships for African American women who have mothers with BPD do not have to mirror their negative mother-daughter attachment experiences. She shared: "African American women, non-Black women…when it comes to relationships, know that your mother's illness in not your own." Participant 5 insisted that having a mother with BPD dose not have to taint an adult daughter's social outlook and expectations for interpersonal experiences. She provided the following statement: "I want to let people know that as hard as it may seem and as painful as it can be to have a mother with BPD, the whole world is not your mom. The whole world is not going to act and treat you like your mom."

**Concluding Comments**

Participants were finally asked if they wanted to share any final comments about their relationship and attachment experiences an as African American adult woman with a mother who has BPD. Participants commented on the impact that BPD has on families, shared their thoughts on being an African American woman and having a mother with BPD, expressed appreciation for this research study, and emphasized on the importance of supporting their mothers. Table 11 presents a summary of the results. Several key words and phrases provided as open codes for subthemes attributed to these major themes.

Table 11

*Summary of Themes for Participants' Concluding Comments*

| Axial Codes (Themes) | Open Codes (Subthemes) | Key Words and Phrases (Codes) |
|---|---|---|
| Impact Of Serious Mental Illness (BPD) | Negatively impacts families | I didn't want a mentally ill mother<br>trauma passed down from generation to generation<br>children with mentally ill parents go through difficulties<br>negatively impacts our children and families |
| | Enduring mental health stigmas | mental health issues normalized in Black families<br>African-Americans, we're not big on mental health<br>Black families take a negative view of therapy |
| | Fosters desire for better connections with their own families | be normal and give our kids these normal lives<br>raise son different from how mom raised me<br>love on my kids everyday<br>I do the best I can with my own daughter |
| Daughters' Insights On Maternal Mental Illness | Reflections of Black daughters with mothers with BPD | being a Black woman having a mother dealing with this disorder is unique<br>children like me are definitely not alone<br>African American women who have mothers with a BPD diagnosis are real<br>Black daughters come from challenging households<br>these women have the same experiences that I have with my mom<br>symptoms and experiences that other Black women have sound exactly like mine<br>children like me are definitely not alone |
| | Eurocentric focus on mental health | mental health treatment has a Eurocentric slant<br>most psychological research does not include African-Americans/ more research in this area |
| | More Black mental health professionals | Psychology and therapy for Black people helpful<br>more Black psychologists and psychiatrists<br>mental fragility, illness and disturbances affect African American women |
| Appreciation For Research | Research on African American female mental health | glad you're doing this research/ research needed/research important<br>happy to be able to be a part of this research<br>this interview is cathartic in a way<br>your research is giving us a voice |
| Support | Support mother | learn how to be an ally, advocate and support system for my mother/ be there for mom<br>want her to take care of her brokenness<br>can condemn my mother's behavior and still love and want the best for her |

**Theme 1: Impact Of Serious Mental Illness (BPD).** A major theme to emerge from this enquiry was participants acknowledging the impact that BPD has on the families of those who suffer from the disorder. Participants reported on their understanding of the harmful influences that BPD can have on family relationships as well as the individual mental health of family members. This was reflected in Participant 9's response, where she described her family's trivializing attitudes towards intergenerational mental illness due to unaddressed trauma, and how those negative experiences may have resulted in the mental disorder that her mother struggles with in present day. Participant 9 shared the following:

> "You know, as a girl growing up, and especially as a Black girl, I really didn't want to live in a reality where I had a mentally ill mother. I mean, like, what does that mean? Growing up in a Black family, mental illness was not at the forefront of our daily struggles or concerns, even if it should have been. You were taught that if you didn't act a certain way, you were funny, or crazy, or, you'll get over whatever it is. But as I learned more about the diagnosis and how it's likely caused by unaided to traumatic events during childhood, I felt more sorry for my mother. I kind of had to think, 'well what trauma did she have to endure to come out with a mental illness?'"

Participant 7 explained how a parent with a mental disorder could negatively influence their children's lives. She disclosed:

> "I think it's really unfortunate and sad that children who have a mother or father with a mental illness have to go through the types of tragedies and experiences

> that we go through. Having any type of parent or any type of person that is looking after you be different in that way can negatively affect your life. And because of that, I think that mental illness is more rampant than people like to admit. There are a lot of people with defective personalities walking around out here."

Additionally, Participant 10 explained how mental, emotional and behavioral health problems might underlie some of the psychosocial issues that continue to negatively impact African American families and communities. She endorsed the importance of African American women seeking mental health treatment for their betterment as well as for the wellbeing of their families. She provided the following response:

> "These cycles of poor mental health, emotional and disturbed personality and flawed interpersonal skills along poverty continue to hurt us, our communities and negatively impact our children and families, you know? But as African American women that suffer through these issues, it's also our responsibility to get help. If you don't feel right or you feel like your emotions are always up, or you feel depressed and you're always down or stressed or angry, go get professional help because our wellness does matter.'

A few participants reported on persisting mental health stigmas that remain prevalent within the African American community. They explained how conversations and responses that normalize symptoms associated with mental illness within African American families can discourage African American families from acknowledging the abnormal nature of mental illness. For example, Participant 2 described how the African

American side of her mixed race family typically holds more of a dismissive and normalizing attitude towards a loved one who demonstrates behavior associated with mental illness. She shared the following experience:

> "I have a mixed race family. My mom's family is predominantly Black, my dad's family is predominantly White. So, I think both sides of my family have a very different take on mental illness. With my Black family's situations, experiences or conversations regarding mental illness, it's like 'whatever', 'her mom crazy', 'you know what she's like', 'oh, you know her', 'you know how [mother's name redacted] do'".

During Participant 5's interview, she gave detail on how her family typically chooses to avoid interacting with her mother rather than aim to understand her mother's mental health condition. Participant 5 shared:

> "Like many African American families, we're not big on mental health. So instead of looking at it as a mental illness, they would rather cut my mom out of the good family time".

A couple of participants also expressed how they had a desire to form better attachments with their children in spite of the experiences that they had with their mothers. Participant 6 articulated this aim in her interview: "But now that I'm older and I have my son I'm trying to do things differently." Participant 2 described how struggles associated with being raised by mentally ill parent can shape the desires and concerns that adult offspring have for their own children. She shared how being raised by a parent with

a mental disorder can expose future generations to interpersonal challenges as well as have genetic implications. She explained:

> "It seems the kids have inherited new problems because of what we went through. I think we were so determined to be normal, and to give our kids normal lives. Like now, we as adult children of mentally ill parents have tried to go against everything that was stacked against us. We wanted to be normal and give our kids these normal lives, but now it's like they're fighting against genetics."

**Theme 2: Daughters' Insights On Maternal Mental Illness.** Another major theme to emerge from this question was the experiences that participants wanted to share about being an African American woman who has a mother with a personality disorder. For instance, Participant 1 explained that being a Black woman and having a mother dealing with BPD is a unique experience. She expounded that because this disorder is very rarely addressed or talked about for Black women and Black mothers, knowing that her mother has BPD makes her and others of this similar background rare. Participant 6 shared how Black daughters who have mothers with BPD have embattled relationship histories with their mothers, which can result in insecure attachments and entering into unhealthy relationships. Participant 6 shared:

> "I want people to understand that Black daughters who have mothers with borderline personality disorder are coming from challenging households. We are coming from those types of relationships where we have really gone through a lot; therefore, we may not always find ourselves in the best relationships or best friendships."

Several participants implored for the need for more African American representation in mental health research and therapeutic intervention solutions. They acknowledged racial disparities that have conventionally steered mental health studies and continue to spearhead mental health research in the present day. Additionally, participants recognized that mental health interventions and strategies geared towards mental health wellness have been traditionally structured in a manner that has disadvantaged African Americans from opportunities to pursue and maintain mental and emotional wellness. For instance, Participant 1 addressed the Eurocentrism in mental health studies and interventions, and how this disparity continues to overshadow the necessity for ethnically considerate perspectives in mental health research. She explained:

> "There's been so much research that's shown that therapy and mental health treatment focuses on, as most medicine does, um, has a very Eurocentric slant. So there hasn't been a lot of studies done specifically dealing with African Americans dealing with mental health issues."

The sentiments expressed by participants for more research on African American female mental health ultimately led to participants emphasize the need for more Black mental health professionals. For example, Participant 1 stated during her interview that there is a need for more Black psychologists and psychiatrists. Participant 6 revealed a similar inclination during her interview, as she reasoned that a sparsity of African American mental health professionals could lead to a cultural ignorance towards mental disorders that affect African American women. She commented:

> "I want people to be able to know that Black psychology and therapy for Black people and Black mental health are extremely helpful. But because of the scarcity of research, how are we supposed to know that these disorders exist among African American women?"

Participant 9 stated how she wants society to be more aware that mental health disturbances and disorders impact African American women the same way that such difficulties affect individuals of other races. She also discouraged ascribing negative stereotypical characterizations to African American women who could be suffering from underlining mental health problems. She responded:

> "I hope society makes more of an effort to acknowledge that mental fragility, illness and disturbances affect African American women too; and that doesn't make us 'angry black women' or crazy. As an African American woman, I can be strong, vulnerable, happy, sad, resilient or exhausted. I can be a whole human being that is free to express myself in healthy and well-rounded ways. I can be a woman of faith and seek therapy."

**Theme 3: Appreciation For Research.** Numerous participants expressed gratitude for this research topic. Such was the case for Participant 1. She indicated that she was glad that this research was being done because "this work is definitely needed." Participant 6 admitted to a similar sentiment during her interview as she provided the following response: "I am so happy to be able to be a part of this research and I'm so happy that you are doing this study." Participant 9 also endorsed this research endeavor by echoing a similar support: "Your topic is an excellent one because we need more

research in this area for African American women." Participant 11 expressed her support of this research by commenting: "I think it's notable what you're doing here with this research. Your research is inspiring and is finally giving us a voice."

**Theme 4: Support.** The final theme to emerge from this enquiry was the support that participants felt towards their mothers who have BPD. They explained how they have an understanding that their mothers' illness is likely a result of traumatic experiences that their mothers endured during their formative years. Participants also explained that in spite of their mothers' negative treatment towards them, they still felt inclined towards being allies for their mothers. For example, Participant 5 explained how she supports her mother regardless of the criticism that her mother receives from other family members. She revealed**:**

> "My immediate family and I don't have any relationship with my mom's side of the family, and it's painful. It really sucks because you have cousins and see all these things on Facebook that you really can't associate with because it's like 'yeah my mom does have problems, yeah my mom does have a lot of issues, but I still have to be there for my mom. I still have to be on her side. I still have to like respect her in a sense.'"

Participant 6 shared the belief that her mother's unhealthy self-concept is a result of BPD. She explained that although her mother's behavior is consequentially responsible for their stained relationship, she desires for her mother to seek help for her mental illness. She explained: "I truly don't feel like my mother hates me. I feel like all of her actions and her emotions and her personality comes from a place of brokenness. And I ultimately

want her to admit that and take care of that." Participant 9 explained how she can support her mother without compromising her own wellbeing. She responded: "Yes my mother has borderline personality disorder. Yes, I can condemn my mother's behavior as a result of her disorder and still love and want the best for her. I can be there for her in ways that don't end up hurting me or sacrificing my happiness anymore."

## Summary

In this chapter, the findings revealed that African American women who have mothers with BPD have endured difficult and challenging mother-daughter attachment and interpersonal experiences. These experiences ultimately shaped their attachment orientations, relationship ideals, and mental health and wellness outlooks. The findings showed that African American mothers who have BPD significantly influenced the attachment patterns and bonding behaviors of their daughters, generally in a disadvantageous way. However, the data revealed that relationship and attachment adversities experienced by African American adult daughters of mothers with BPD proved that such challenges can also cultivate a desire in daughters to employ positive attachment practices. The data also revealed that in spite of the difficulties experienced within these mother-daughter relationship experiences, African American adult daughters were capable of pursuing and forming healthy attachments with others and had the ability to hold positive views of close relationships.

Findings from this inquiry additionally showed that due to having a mother with BPD, African American women vehemently discouraged the ascription of negative social epitomes synonymous with the African American female experience such as the "angry

Black woman" stereotype and the SBW schema. African American women who have mothers with BPD argued that possible underlining mental health issues could be mislabeled or dismissed as culturally normative archetypal expressions, such as African American women being characterized as "crazy" when they could be suffering from a psychological distress. Thus, African American women with mothers who have BPD strongly endorsed the utilization of therapy and other supportive interventions like one-on-one therapy, online support groups and family support. They also implored for the increased presence of mental health research that represents and serves Black people, and advocated for more Black mental health professionals and culturally sensitive mental health interventions. The following chapter will provide a comprehensive interpretation of the findings, the limitations of the study, recommendations, conclusion, and implications for social change.

# Chapter 5: Discussion, Conclusions, and Recommendations

## Introduction

The purpose of this qualitative phenomenological study was to explore adult attachment in African American women who have mothers with BPD. Specifically, I gathered information on how early exposure to their mothers' mental illness may have affected participants' attachment with their mothers as well as others. I also examined how their attachment experiences with a mother who has BPD shaped participants' views on intimate relationships and mental health. Findings from this study revealed that participants who have mothers with BPD experienced interpersonal and intrapersonal challenges as a result of their mother-daughter attachment experiences. The data further showed that participants had a difficult time forming healthy attachments with others as a result of the difficulties they endured during their attachment and bonding experiences with their mothers. Results from this study also revealed that in spite of their difficult mother-daughter interpersonal experiences, participants used positive descriptives to define a close relationship. Ultimately, participants suggested more research in the area of mental health and therapeutic interventions for African American women, and they championed the utilization of culturally sensitive mental health treatment. The major themes that emerged from the study supported premises of attachment theory and the four-category model of adult attachment, both of which postulate that attachment patterns formed in childhood have persisting effects on relationships in adulthood (Bartholomew & Horowitz, 1991; Bowlby, 1969, 1982). Several major themes resulted from the data.

## Interpretation of the Findings

The results of the literature review in Chapter 2 revealed that BPD complicates the attachment bond between mothers and their offspring and may in turn lead to an anomalous pattern of attachment between them (Beeney et al., 2015; Lawson, 2016; Miano, et al., 2017; Zalewski et al., 2014). Moreover, offspring who have mothers with BPD have been found to be at an elevated risk of encountering various negative psychosocial outcomes, including developing insecure attachments that result in dysfunctional interpersonal connections (Etienne, 2011; Everet alt et al., 2016; Macfie et al., 2017). In this section, I will interpret the key findings for this study and discuss how the findings relate to those from previous research.

### Learning of Mother's Diagnosis

In the interviews, I asked participants how they found out about their mothers' diagnosis. The data revealed that participants learned of their mothers' BPD diagnosis by way of a formal diagnosis and/or through informal means. Numerous participants shared that their mothers either authorized a clinician to share their BPD diagnosis with them or disclosed their diagnosis directly with participants, or they discovered medical records documenting their mothers' diagnosis. Participants' learning of their mothers' mental illness diagnosis through a formal means aligns with National Institute of Mental Health (2019) report that a licensed mental health professional such as a psychiatrist, psychologist, or clinical social worker experienced in diagnosing and treating mental disorders can clinically diagnose BPD.

Several participants disclosed how their mothers had multiple diagnoses as well as comorbid mental illnesses that occur alongside BPD. These comorbidities included bipolar disorder, intermittent explosive disorder, narcissistic personality disorder, and depression. Findings from this study support previous research findings, which showed that BPD often accompanies other mood and personality disorders. For instance, empirical evidence shows that BPD can have several comorbidities that include but are not limited to persistent depressive disorder, intermittent explosive disorder, major depressive disorder and narcissistic personality disorder (Beatson & Rao 2013; Perez-Rodriguez et al., 2012; Weinberg & Ronningstam, 2020). Moreover, Petfield et al. (2015) explained that mothers with BPD oftentimes presented with comorbid disorders like major depression, and persistent depressive disorder. Additionally, Burnett-Zeigler, et al. (2019) explained that major depressive disorder has a high prevalence among African American women. Other researchers reported that BPD and bipolar disorder are clinically acute chronic conditions that typically co-occur and share key clinical features such as mood oscillations and general impulsivity (Morgan & Zimmerman, 2015; Paris & Black, 2015).

**Thoughts on Mother's Diagnosis**

In the interviews, I asked participants to share their thoughts when they learned of their mothers' diagnosis. Participants communicated how the diagnosis affirmed all of their difficult attachment experiences with their mothers. Three significant themes emerged from the thematic analysis, one of which was that participants believed that the BPD diagnosis was accurate and affirming. The data revealed how the diagnosis

provided participants with the clarity that they needed in order to explain their mothers' chaotic behaviors and emotional instability. These results support the findings of Kay et al. (2018), who found that family members who have a relative with BPD were able to recognize that their relative has difficulties with emotional, behavioral, interpersonal and self dysregulation, which lead family members to have a difficult time adapting to and coping with their relative who has the disorder.

Another theme to emerge from the data analysis included participants finding that their mothers' borderline personality diagnosis was affirming. Findings from this study revealed that participants found the BPD diagnosis to affirm and validate behaviors in their mothers that some characterized as crazy and unstable as well as "erratic", "scary", "unpredictable" and dangerous". According to Lawson (2016), individuals with BPD typically demonstrate mood characteristics such as unpredictability, explosive emotional outbursts, and malice when expressing distressing emotions. Furthermore, data findings from this study supported inferences from De Genna and Feske (2013), who found that African American women with BPD might demonstrate acute symptoms associated with the disorder such as lack of anger control. Evidence suggests that personality disorder indicators include extreme behavior, anger, rapid temperament shifts, unstable interpersonal relationships, and intense emotional reactions (Franklin 2015; Westbrook & Berenbaum, 2017). Consequently, participants' descriptions of their relationships with their mothers as well as their mothers' behavior are consistent with what has been identified in previous literature regarding behavioral indicators associated with personality disorders.

A third theme to emerge from the data analysis included participants feeling unsettled about their mothers' BPD diagnosis. Participants explained that while knowledge of their mothers' disorder helped them better understand their mothers' behavior as well as their mother-daughter experiences, they found the diagnosis to be disconcerting. These findings support a considerable amount of literature on offspring perspectives on their parent's mental illness condition (Fertuck et al., 2018; Patrick et al., 2019; O'Donohue & Lilienfeld, 2013).

**Feelings About Mother's Diagnosis**

In the interviews, I asked participants to share how they felt about their mothers' diagnosis. The thematic analysis revealed that participants were displeased that their mothers had a mental illness as they described feeling depressed, sad, angry, and ashamed. Feelings of displeasure as expressed by participants align with assertions by Kreisman and Kreger (2018) that loved ones of those with BPD can experience feelings of confusion, stress, anger, and embarrassment. Furthermore, study results coincide with researcher findings that BPD can cause family members to experience feelings of carer burden, anxiety, and stigma (Kay et al., 2018; Kirtley et al., 2019; Kreisman & Kreger, 2018; Patrick et al., 2019).

Adult offspring of a parent with mental illness have typically been found to have a strained relationship with their parent (Patrick et al., 2019). However, the data in this study showed that in spite of the displeasure they felt about their mothers' diagnosis, participants also expressed that they had compassionate and supportive feelings towards their mothers as a result of the knowledge they held about their mothers' tumultuous

childhood experiences. This understanding was reflected in the data as participants identified a possible link between their mothers' early childhood trauma and their mothers' current mental health condition. These findings supported those of Murphy et al. (2018), which suggested that adult offspring with parents who have a mental illness have been found to seek a greater understanding of mental illness and its contributing factors.

**Nature of Relationship After Learning of Mother's Diagnosis**

In the interviews, I also asked participants to share how their mothers' BPD diagnosis influenced the nature of their mother-daughter relationships. Two major themes emerged during data analysis. The first major theme to present included some participants reporting that their relationship with their mother became more difficult or in some cases did not change/improve. These findings coincided with assertions from Lazarus et al. (2019), who explained that relationships burdened with conflict are a hallmark of close connections for those with BPD. Furthermore, according to the American Psychiatric Association (2013), relationship difficulties tend to be an enduring characteristic of BPD interpersonal relationships.

The second major theme to emerge for the data analysis was several participants modifying how they related to their mothers. Due to the cyclical nature of their embattled mother-daughter relationship experiences, participants expressed how they had to modify some of the ways in which they interacted with their mothers. They shared how they use their knowledge of their mothers' diagnosis to navigate through various mother-daughter relationship challenges in an attempt to positively influence their

interpersonal outcomes as well as better understand their experiences. Researchers have suggested that taking note of harmful and negative patterns of behavior in relatives with BPD allows family members to more appropriately assess their experiences when interacting with a loved one who has the disorder, and become better prepared for their interactive encounter outcomes (Arterburn & Wise, 2017; Kreisman & Kreger, 2018).

**Attachment and Bonding With Mother**

In the interviews, I asked participants how their mothers' diagnosis affected their abilities to establish an attachment with their mothers. The major theme to emerge from the data analysis was participants finding it difficult to establish attachments and bonds with their mothers. They described attaching and bonding with their mothers as "hard" "strained" and "very distant". According to Turner, Sebastian and Tüscher (2017), individuals who have Cluster B personality disorders (like BPD) typically have a difficult time sustaining healthy relationship attachments. Furthermore, evidence suggested that establishing secure parent-child attachments and bonds can be difficult for children of someone with BPD (Bateman & Fonagy, 2018; Crowell, 2016; Petfield et al., 2015). Findings from this study further align with assertions by Florange and Herpertz (2019) who explained that a diagnosis of BPD in mothers could inhibit the development of a healthy parent-child relationship. Participants additionally characterized their relationships with their mothers as turbulent, as they explained the "up-and-down" nature of their mother-daughter attachment and bonding experiences. These findings support similar findings from Fossati and Somma, (2018) who explained that people who are in

close relationships with individuals who have BPD are likely to be involved in tempestuous, “roller coaster” relationships.

An analysis of the data additionally revealed that knowledge of the Karpman Drama Triangle helped daughters who have mothers with BPD recognize dynamics behind some of the contentious interpersonal experiences that they endured with their mother. This finding supports evidence in the literature review regarding the association between this codependency drama triangle and individuals with BPD. According to Pearce and Critchlow (2019), people with BPD typically act out each dysfunctional role of the triangle. Moreover, Liotti and Farina (2016) suggested that children who were raised by parents with BPD are akin to the three basic roles of Karpman’s (1968) drama triangle.

**Current Relationship With Mother**

In the interviews, I asked participants to describe their current relationships with their mothers. During the thematic analysis of the data, three significant themes emerged. One major theme was participants finding their current relationship with their mothers to be generally distressing. Several participants described their current relationships with their mothers as strained, tumultuous, and worse than in prior years. A significant amount of literature on maternal BPD and offspring attachment shows that maternal BPD complicates mother-child attachments, and thus yields enduring relationship strains between mothers and their offspring (Florange & Herpertz, 2019; Kluczniok et al., 2018; Petfield et al., 2015; Zalewski et al., 2014). Findings from Pickering et al. (2015) revealed that lived and perceived negative mother-daughter relationship and attachments

experiences heavily influenced how daughters viewed and defined their overall relationships with their mothers. Furthermore, findings from this study coincide with assertions by Lawson (2016), who explained that offspring of mothers who have BPD remain at an increased risk of developing insecure attachments to their mother.

The second theme that presented during this analysis included participants separating from their mothers by physically and/or emotionally distancing themselves in an effort to escape interpersonal conflicts with their mothers. Participants explained that maintaining geographical and/or emotional distance from their mothers supported them in their efforts to invest in healthy attachments and bonding with their own families, avoid anxiety, and preserve any supportive feelings or cordiality that they had remaining for their mothers. Findings from this study supported those of Fossati and Somma, (2018), who asserted that living with a loved one who has BPD can cause emotional strain, and could lead to emotional distress including anxiety, anger, self-reproach, frustration, desolation, and despondency in family members of those with BPD. Furthermore, the mother-daughter attachment and bonding experiences of participants corroborated with ample research evidence that suggests that people with BPD have a profound inability to sustain stable interpersonal relationships (American Psychiatric Association, 2013; Bilek et al., 2017; Franklin, 2015; Romaniuk et al., 2016; Streit et al., 2020).

The third theme to emerge from this analysis included participants believing that their relationships with their mothers improved due to their understanding of their mothers' mental health condition. They explained how this knowledge inspired them to work with their mothers in a collaborative effort in order to maintain a mother-daughter

connection. There is a substantial amount of literature that addresses the adverse relationship outcomes between mothers with BPD and their offspring; however, Miller and Skerven (2017) found that relatives of family members with BPD who received psychoeducation about emotion regulation disorders and learned skills related to core mindfulness, validation, interpersonal effectiveness, emotion regulation, and radical acceptance showed a decrease in interpersonal sensitivity. Furthermore, findings from this enquiry coincided with the assertions of Murphy et al. (2018), who explained that adults who have lived with a parent with mental illness desired to have a greater understanding of their parent's mental illness. Findings from this study also supported the claims of Kreisman and Kreger (2018), who explained that loved ones of those who suffer from BPD can learn various way to be allies for their loved ones who have the disorder.

**Definition of a Close Relationship**

In the interviews, I asked participants how they define a close relationship. Four themes emerged for the thematic analysis, which included participants defining close relationships as bond that demonstrate nearness, practice pardoning, are cultivating, and extend loyalty. Participants shared their understanding of close relationships to be interpersonal connections that involve honesty, support, understanding, and intimacy. According to researcher claims, individuals who were raised by parents with emotional regulation problems (like parents with BPD) tend to hold distorted views of what defines a stable relationship, and this may in turn prevent them from forming close relationships in adulthood (Gibson, 2015; Noon, 2017). However, participants for this study expressed

generally hopeful outlooks on relationships despite their past mother-daughter relationship experiences and current patterns of attachment. Participants' explained that their negative mother-daughter attachment experiences motivated them seek to an understanding of what healthy relationship and connections entailed. Understanding healthy relationship dynamics as well as successfully forming healthy attachments within other interpersonal relationships ultimately helped participants form hopeful and positive definitions of close relationships. Data results from this study support those of Murphy et al. (2018) who found that adults who have lived with childhood parental mental illness can be hopeful for prospective positive interpersonal relationship outcomes. Furthermore, Pietromonaco et al. (2013) explained that individuals who form expectations, beliefs, and desires about close relationships based on childhood attachment experiences with caregivers are typically open to revising their internal working models of attachment based on experiences in later intimate relationships.

**Impact on Current Ability to Form Attachments**

In the interview, I asked participants to share how their attachment experiences with their mothers influenced their current ability to form close relationships with others. Three major themes emerged from the data analysis, one of which was participants finding it difficult attach and form bonds with others. Data from this research indicated that many participants had a difficult time establishing secure interpersonal attachments with others as a result of having a mother with BPD. Participants explicated their disordered relationship histories, told of their experiences with intentional intimacy avoidances within their platonic and romantic relationships, described challenging

relationship pursuits as “natural”, and told of an underlining weariness when considering forming new interpersonal attachments and establishing bonds. Participants finding it challenging to initiate forming secure attachments with others align with a significant amount of literature on insecure attachment outcomes for offspring of mothers with BPD; in that offspring may find it challenging to trust others, which may in turn impede their ability to form healthy attachment patterns in adult relationships (Balsam & Fischer, 2014; Bartsch et al., 2015; Bateman & Fonagy, 2018; Aguirre & Galen, 2013; Jackson, 2016; Masland & Hooley, 2019; National Institute of Mental Health, 2016; Petfield et al., 2015; Streep, 2017). Findings from this study are also consistent with evidence that attachment insecurities towards a parent are transferable to various other interpersonal connections (Ahmed & Brumbaugh, 2014; Holmes, 2014a; Sirois et al., 2016), and that adults who lived with childhood parental mental illness have been found to struggle with connecting with others (Murphy et al., 2018). Data from this study additionally support conclusions from Tinsley (2016), who asserted that attachment style and level of satisfaction (e.g., relationship dissatisfaction) within relationships for African Americans could be related to a failure to establish secure attachments with one or both parents.

Another major theme to emerge from the data analysis was participants having compromised interpersonal relationship attributes. The findings revealed that a number of participants approached new relationships with an underscoring apprehension towards connecting and bonding in fear of being overwhelmed or underappreciated, or had a fear being “smothered” by potential attachment figures. Gibson (2015) explained that due to the unstable emotional and behavioral encounters that adult offspring have experienced

with their parents who have emotion regulation difficulties (like parents with BPD), adult offspring may ultimately perceive close relationships to be burdening or confining. What is more, a review of the literature revealed that adult daughters of mothers with BPD may feel exhausted by the time they head into adult relationships because of their disordered mother-daughter relationship experiences (Gibson, 2015; Lawson. 2016; Noon, 2017, Streep, 2017).

According to adult relationship attachment theorists Hazan and Shaver (1994), individuals who have weak attachment patterns experience feelings of inadequacy and ultimately have a lack of shared intimacy within relationships. Some participants expounded their fear of intimacy as well as their concerns about their value within their interpersonal relationships. Researchers have indicated that African American mothers have a significant role in shaping how their daughters perceive themselves as well as how they relate to others (Baugh & Barnes, 2015; Everet alt et al., 2016). Results from this study additionally support literature findings that adults who lived with childhood parental mental illness have been found to experiences feelings of uncertainty within interpersonal relationships ((Murphy et al., 2018).

An analysis of the data presented another major theme that revealed that African American women with mothers who have BPD also had the capability to develop desires to establish healthy attachments with others in spite of their negative mother-daughter attachment experiences. This data supports the claims of Hofer and Hagemeyer (2018), who explained that people have an innate desire to form and maintain relationships with others irrespective of cultural background.

**Insights Gained About Mental Illness**

In the interview, I asked participants how their experiences of having a mother with BPD affected their knowledge and understanding of mental health. Five major themes presented in the analysis of the data, one of which was the consideration that participants had for those with mental illness. Results from this study revealed that participants came to understand the importance of mental health through the experience of having a mother with BPD. They additionally explained how they came to understand the severity of mental health issues as well as the importance of mental health wellness, especially for African American women. These findings support the assertions of Murphy et al. (2018), who explained that understanding how parental mental illness impacts families is crucial.

The data revealed in another theme that participants supported the expansion of knowledge and understanding on mental illness. Participants supported more research geared towards mental health in African Americans and expressed their desires to pursue an education or profession in the field of mental health. These findings were in line with a considerable amount of literature that highlighted the understudied, underserved, and underrepresented presence of African American women in clinical research (Carr et al., 2014; George et al., 2014). Additionally, research evidence suggests that in spite of the ample amount of literature on treatments and interventions for populations struggling with mental illness, there still remains a scarcity in community-based culturally competent clinicians (Hamm, 2018).

The transgenerational nature of mental illness was another theme that was identified within the analysis of the data. Results from this study revealed that African American women who have mothers with BPD understand how mental illness can impact families generationally. An analysis of the data showed that participants acquired their own personal diagnosis of BPD as a result of exposure to their mothers' disorder. Participants also shared how they struggled with anxiety and depression as a result of having a mother who has BPD. These data results support findings from the literature review that showed that children who have parents with BPD are at a heightened risk for suffering from depression, anxiety and BPD itself, and have poorer overall mental health compared to offspring of psychologically healthy mothers as well as offspring of parents who suffer from other mood disorders like bipolar disorder (Campbell, 2020; Küng et al., 2019; Murphy et al., 2018; Petfield et al., 2015).

Participants explained how immediate family members demonstrated behavioral characteristics that fulfilled criteria for mental disorders. This included participants observing family members (e.g., siblings) display characteristics associated with affectionless psychopathy. Participants also acknowledged a possible genetic disposition to person developing BPD. These findings align with research done by Kerr et al. (2018), who found parental BPD to be associated with an increased risk of offspring psychopathology. The data further revealed that participants believed having a mother with BPD genetically predisposed their families to the disorder and imparted maladaptive behaviors associated with BPD onto them as well as other family members. These results support finding from the literature review that revealed that significant links have been

found between personality disorders and gene expression, with evidence supporting the epigenetic processes in the development of personality traits and personality disorders (Gescher et al. (2018). Moreover, data from this study support the assertions of Ruocco et al. (2019) that genetic markers in BPD pose a great risk to families.

Another theme to emerge from the data analysis was that a number of participants had relatives that held trivializing views towards mental illness and the significance of mental health interventions. Participants disclosed how discussions surrounding therapy and mental health in their families as well as in the African American community largely perpetuated undervaluing attitudes towards therapy. These results support findings from Ward et al. (2013) who found that African American attitudes towards mental illness and seeking mental health services impacted how willing African Americans were to acknowledge mental illness. Furthermore, findings from this study support data from National Alliance on Mental Illness (2016) that showed that recognizing and acknowledging mental illness remains a problematic issue for African Americans. Findings from the literature review also showed that African Americans remain the least likely racial group to pursue and receive mental health care services (Hollar et al., 2018; National Institute of Mental Health, 2016). What is more, many African Americans have been found to believe that discussions and problems associated with mental health and mental illness would not be appropriate to address even among family (National Alliance on Mental Illness, 2016). In turn, difficulties regarding the ability to identify mental illness for African Americans can lead many within this community to underestimate the

impact of issues related to mental health problems (American Psychiatric Association, 2013).

Another significant theme to emerge from the data analysis included participants' disdain for categorical social ideologies about Black Women, most notably the SBW schema. Participants shared their beliefs on how African American girls are conditioned to pursue this image when they mature into adulthood. They also expressed how stereotypical and dismissive labels towards vulnerability in Black women (like the SBW myth) presented more of a harmful impact rather than fortified the mental and emotional health of Black women. Participants understood the SBW ideology to be a deterrent for Black women to express their mental and emotional fragility, dissuade them from vocalizing their distress, and consequently cause them to neglect self-care. Findings from this study were consistent with findings from the literature review that revealed that Black women who pursue the SBW role limit their quality of being by embracing undue social pressures to live up to social expectations associated with this ideal (Liao et al., 2019; Nelson et al., 2016; West et al, 2016). Data results of this study also support research evidence that the SBW social construct negatively influences Black women's ability to seek help, and predisposes Black women to various adverse psychological outcomes including distress, depression and suicidal ideation (Hollingsworth et al., 2017; Nelson et al., 2016; Watson & Hunter, 2015). Moreover, Woods (2013) found that the fervent endorsement of the SBW paradigm was considerably related to reduced intents to seek mental health treatment among African American women.

**Having a Mother With BPD**

In the interview, I asked participants if there was any additional information they would like to share with others pertaining to how having a mother diagnosed with BPD affects a person's outlook on relationships. Thematic analysis for this enquiry revealed five emergent themes. One theme showed that African American women who have mothers with BPD experienced interpersonal challenges associated with disorganized mother-daughter attachments. These challenges included difficulties establishing healthy self-identities, relationship issues, and bonding difficulties. These results support findings from Mikulincer and Shaver (2019) who explained that attachment insecurity can negatively influence an individual's social wellbeing and can negatively impact their interpersonal relationships. Moreover, a review of the literature revealed that an individual's mental wellness, self- identity, outlooks on attachment and adult interpersonal relationship skills are a result of life experiences that they shared with their caregivers (Sirois et al., 2016).

Another significant theme to present from this data analysis was participants endorsing group support and therapeutic intervention for people who have loved ones with BPD. Participants disclosed how participating in in-person therapy sessions helped them endure, confront, and heal from their difficult mother-daughter interpersonal experiences. They also shared how virtual support systems (e.g., online and social media support groups for family members or relatives with BPD) supported their therapeutic pursuits. Results from this study also supported findings from Metz and Jungbauer (2019), who claimed that adult offspring who were raised by parents with a mental illness

emphasized the need for professional support and intervention. Furthermore, Bailey and Grenyer (2015) explained that carers of relatives with BPD may benefit from intervention and support options considering their challenged interpersonal dynamic, carer burden and impaired carer wellbeing. A review of the literature further indicated that offspring of mothers with emotion regulation disorders like BPD can benefit from therapy intervention (e.g., mentalization-based therapy) because this approach has been found to improve various interpersonal outcomes for family members of individuals with cognitive-behavioral and emotional disorders (Asen & Fonagy, 2012; Wilks et al., 2017).

Another thematic revelation showed that in spite of their complicated relationship histories, participants developed empathic dispositions such as sympathy and patience toward their mothers as well as for people who suffer from mental health issues. Research evidence suggests that children with parents who have BPD can grow up to be egocentric and demonstrate affectionless psychopathy towards others (Gibson, 2015; Kaufman et al., 2017; Petfield et al., 2015). However, findings from this study supported recent evidence that found that adults who grew up with a parent with mental illness had an interest in greater understanding mental illness and a had desire to support their loved ones with mental disorders (Kreisman & Kreger, 2018; Murphy et al., 2018). Moreover, findings from Fonagy, and Rentfrow (2018) suggested that childhood traumatic experiences (e.g., childhood emotional neglect leading to insecure attachment experiences) (De Bellis & Zisk, 2014) can lead to an increase in an individual's empathetic abilities.

A forth theme to present during the data analysis was participants being hopeful for future healthy attachment and bonding experiences. According to Streep (2017), children who grow up with a parent with an emotion dysfunctional disorder may adopt the belief that intimacy within meaningful relationships is unachievable. However, results from this study showed that African American women who were raised by mothers with BPD can develop hopeful relationship outlooks. A few participants shared that in spite of some of the challenges that they face when forming and maintaining secure attachments, their understanding of interpersonal relationships include trusting others, pursuing intimate connections, and having hope for healthy attachments and bonding experiences.

The final theme to emerge from the data analysis included participants pursuing intrapersonal healing. Baugh and Barnes (2015) explained that Black mother-daughter relationships influence the development of overall self-image in Black daughters. A review of the literature revealed that adult offspring who were raised by parents with mental illness could suffer from various negative psychosocial outcomes including lower self-worth compared to adults in the general population (Murphy et al., 2018; Patrick et al., 2019). However, evidence from this study showed that African American women who were raised by mothers with BPD were found to be capable of forming positive attitudes towards intrapersonal wellness and healing. Several participants told of their efforts in restoring their self-identities as well as their choice to adopt positive personal relationship and life outlooks despite their challenging mother-daughter attachment experiences.

**Concluding Comments**

In this interview, I asked participants if they had any concluding comments about their attachment and relationship experiences an as African American woman with a mother who has BPD. Four themes presented during the analysis of this enquiry. One theme included participants recognizing the acute nature of mental illness. Participants shared how their experience of having a mother with BPD enlightened them to the negative impact that BPD and mental illness in general has on families. They further expressed their concerns about how negative stigmas towards mental health still prevail within the African American community. These findings support the claims of Chandler (2019), who argued that a number of negatives stereotypes (e.g., community opposition to mental health intervention, individual disparaging outlooks on mental health support) discourage African Americans from addressing psychological issues. Moreover, while a significant amount of literature findings have reported on the generational influences that BPD has on attachment behaviors and connectedness within families (Cullen et al., 2014; Gambin et al., 2018; Hunt et al., 2015; Kaufman et al., 2017; Stepp et al., 2012), a few participants of this study told of their desires to establish healthy attachments with their own families. These results support findings from the literature review that family members who have a relative with BPD can desire to pursue harmony and integration for their families (Kay et al., 2018).

Another theme to emerge from the data analysis was participants sharing their insights on maternal mental illness from the perspective of African American women. Participants explained how the narratives of African American women who have

experiences associated with a mother with BPD should have more of a presence in mental health research. They shared their views on how mental health and psychology studies and intervention models present a "Eurocentric slant" when producing research about mental health and treatment. Participants also vocalized their desire for more Black mental health professionals. Findings from the literature review showed that BPD has been a racially understudied mental illness in psychiatric literature (Cahn, 2014; McCloud, 2013). Additionally, results from this study support evidence that shows that African American women remain at an increased risk for mental health challenges in part due to limited access to culturally competent and/or minority clinicians (Hamm, 2018).

Another identified major theme from the data analysis included participants expressing their appreciation for this research study. Participants expressed their delight and gratitude for their narratives being delivered through this study. These sentiments support researcher findings that there remains a scarcity in literature on psychiatric disorders and the differences in confirmed outcomes for Black and White individuals (Erving et al., 2018).

A final theme to emerge from this analysis included participants expressing their support for their mothers. Thematic analysis of the data revealed that some participants were moved by their mother-daughter attachment experiences to provide support for their mothers through serving as some form of a support system for their mothers. They described how they desired to be "allies" for their mothers and believed that they had to "be there" for their mothers. The data also showed that African American adult daughters who have mothers with BPD believed that they could criticize their mothers'

unfavorable behavior and still experience caring feelings for their mothers. These finding support the suggestions of Kreisman and Kreger (2018) who expounded that while relatives of loved ones with BPD should abstain from participating in negative interpersonal experiences, they should dually emphasize their support for the loved one with the disorder.

**Connections With Theory**

African American women who have mothers with BPD disclosed that they contended with various interpersonal issues as a result of their mother-daughter attachment experiences. Relationship and attachment difficulties that participants experienced were justified by suppositions from theories of human attachment and adult attachment. Principles from the underlining attachment theory and the four-category model of adult attachment were evident in the findings of this study. Both attachment theory and the four-category model of adult attachment are pertinent to understanding the findings of this study.

**Attachment theory.** Bowlby assumed that early attachment experiences could have a lasting impact throughout an individual's life (Bowlby, 1969; 1977). The findings from this study confirmed assertions from Bowlby and other attachment theorists in that the attachment histories of African American women who have mothers with BPD influenced how they attach within their adult relationships. Empirical evidence shows that children with mothers who have BPD have a difficult time establishing healthy parent-child relationships due to their mother's insecure attachment styles (Florange & Herpertz, 2019; Holmes, 2014a; Macfie et al., 2014).

Participants in this study relayed how attachment and bonding experiences with their mothers were complicated by their mothers' illness of BPD. The study results revealed that negative maternal attachment and bonding experiences of participants spurred confusion about their value within their mother-daughter relationships and made it hard for them to relate to their mothers. They explained how these relationship difficulties subsequently created an overall strain within their mother-daughter relationships, led participants to develop mistrust towards their mothers, and in some cases caused participants to employ physical distancing between themselves and their mothers. These findings align with the assertions of Bowlby (1954) that a disordered attachment bond between a primary caregiver and child could adversely impact a child's ability to establish a healthy attachment bond with their primary caregiver (typically the mother).

Several participants shared their belief that attachment experiences related to having a mother with BPD predisposed them to the intrapersonal insecurities that they contend with in present day including depression, a limited ability to form close friendships, and a fear that they will struggle with the same maladaptive behaviors as their mothers. Furthermore, data from this study revealed that some participants currently struggle with mental and emotional health conditions, including BPD. These findings coincide with Bowlby's (1977) hypotheses that insecure attachments and bonds could later lead to developmental difficulties and personality disorders. Bowlby (1969; 1977) came to believe that psychological, emotional and behavioral problems could be rooted in faulty early childhood attachment experiences.

**Four-category model of adult attachment.** Adult attachment styles have been described as a collection of knowledge, beliefs, and insecurities that adults hold about themselves and their close relationships (Hazan & Shaver, 1994). Holmes (2014a) suggested that an individual's attachment history has a large influence on how they relate to others in close adult relationships. Furthermore, offspring of parents with BPD were found to be at an elevated risk for developing problematic attachment patterns (Bartsch et al., 2015). Data from this study showed that participants dealt with a number of intrapersonal challenges including difficulty attaching and bonding with others, relationship insecurities, and various maladaptive interpersonal schemas as a result of having a mother with BPD.

Bartholomew and Horowitz's four-category model of adult attachment classified adult insecure attachment styles as anxious-preoccupied, dismissing-avoidant, and fearful-avoidant (Bartholomew & Horowitz, 1991). Individuals who are insecurely attached have a tendency to detach form natural attachment needs, emotions, and behaviors (Holmes, 2014b). Moreover, researchers explained that those who have insecure avoidant-preoccupied, dismissive-avoidant, fearful-avoidant attachment styles have a difficult time being close to others and are characteristically emotionally distant and rejecting of intimate relationships (Bartholomew & Horowitz, 1991; Holmes, 2014b).

Dismissive avoidant and preoccupied insecure attachment styles have been found to be typical attachment orientations for mothers with BPD (Holmes, 2014a; Macfie et al., 2014; Masland & Hooley, 2019). Consequently, Mikulincer and Shaver (2016) explained that attachment styles are transferable to relationships beyond that of child and

caregiver. Findings from this study revealed that while a few participants were able to establish healthy attachments and bonds within their various adult relationships, many participants presented attachments characteristics largely synonymous with dismissive-avoidant and anxious-preoccupied insecure attachment styles.

Participants who had attachment patterns indicative of adults with a dismissive-avoidant attachment style shared that they had various insecure attachment experiences. These insecure attachment experiences included but were not limited to: (a) difficultly developing healthy interpersonal relationships, (b) intimacy avoidance, (c) internalizing emotions, and (d) harboring suspicion towards the intentions of potential intimate partners or close connections. According to literature on adult insecure attachment behaviors, adults with a dismissive-avoidant attachment style tend to be emotionally distant and rejecting towards intimate relationships and may avoid getting involved in intimate relationships all together (Bartholomew & Horowitz, 1991; Holmes, 2014b; Winterheld, 2016). Moreover, Winterheld (2016) explained that adults with dismissive-avoidant styles may find it difficult to bond within close relationships and tend to detach from natural attachment needs, emotions, and behaviors.

Attachment inadequacies as a result of negative mother-daughter attachments fostered various insecurities for participants concerning their abilities to establish healthy attachments within other interpersonal connections. Some participants reported on their codependent tendencies as well as their propensity to be insecure about or within their relationships. The data revealed an insecurity of "being disposable" within close relationships, and a belief by some participants that their value within their relationships

was contingent upon them ensuring the happiness of their loved one or partner. These study results indicated that some participants may have an anxious-preoccupied insecure attachment orientation. According to Holmes (2014b), while adults with anxious-preoccupied attachment styles tend to desire intimate interactions and relationships, they may be insecure about relationships. Such individuals may be depicted as "needy", be insecure within intimate relationships, and constantly worry about abandonment and rejection (Bartholomew & Horowitz, 1991; Holmes, 2014b).

According to Streep (2017), daughters who experienced insecure bonding with their mothers are at a high risk of unintentionally replicating negative bonding styles in other interpersonal relationships. However in spite of Streep's assertions, data results from this study showed that some participants used positive descriptives to define a close relationship. Results from the data analysis further revealed that some participants were able to establish positive relationships. Participants shared their belief that healthy attachments could be pursued with the right partner despite their negative mother-daughter attachment and bonding experiences, and some expressed hope and optimism for future relationships by commenting on their current healthy attachments to their spouses, children and friends. They additionally explained how the negative relationship experiences that they endured with mothers inspired them to pursue healthy relationships in adulthood in order to avoid repeating negative attachment behaviors.

## Limitations of the Study

One limitation of this study to consider was the sample size. The sample size was limited to only African American women because no other ethnicity could

represent this sample populaiton. Additionally, this study specifically addressed adult attachment in African American women who have mothers with BPD. This sample does not represent women of other racial or ethnic groups. Therefore, findings from this study may not be transferable to other racial, ethnic, or culturally diverse populations.

Another limitation was that this study specifically examined African American mother-daughter attachment experiences and borderline personality disorder instead of any other Axis II Cluster B disorder. The sole purpose of this study was to investigate how African American mothers who harbor this particular personality disorder influenced the attachment styles of their adult daughters. Upon conducting an extensive review of the literature, I was unable to located studies on BPD or maternal BPD and the impact that the disorder has on the attachment orientations of African American adult female offspring. Because this qualitative inquiry is unique, transferability of the findings in this study may be limited.

## Recommendations

One recommendation for future research is to conduct a mixed methods study using a triangulation design of African American women and BPD in relation to intimate relationships. According to Quirk et al. (2016), individuals with challenged intimate relationship histories (e.g., marriage separation, divorce) had the highest rates of personality disorders. What is more, Kay et al. (2018) claimed that there is a necessity for mental health care professionals and service providers to expand their knowledge and understanding of BPD and aim to understand the implications of the diagnosis. Researchers could assemble focus groups or conduct individual semi-structured open-

ended interviews in order to gather data on the intimate relationship experiences of participants. This interview protocol can be administered in order to explore intimate relationship dynamics of African American women with BPD. In addition to the thematic analysis, researchers could have participants complete the Intimacy Status Interview for assessing the quality of an individual's capacity for intimacy as well as the Relationship Questionnaire. A descriptive statistical analysis could be run on the results of these surveys in order for researchers to identify associations among African American women with BPD and variables associated with intimate relationship capacity. This statistical summary could allow researchers to conduct further statistical tests in order discover descriptive coefficients that summarize the intimate relationship experiences of this demographic. Transferability may not be generalized to populations outside of African American women who have BPD.

A significant portion of the literature review highlighted the adverse psychosocial, behavioral and relationship outcomes for children who have parents with BPD. However, a review of the literature dually brought light to the scarcity of research on the impact that therapeutic interventions and supports can have on relationship outlooks in African American offspring of parents with a mental illness. Moreover, results from a research study by Metz and Jungbauer (2019) revealed that a large number of adult offspring who were raised by a parent with mental illness emphasized the need for professional support in order to form the ability to efficiently address their daily life challenges. Therefore, another recommendation for future research is a qualitative study using an interpretive phenomenological analysis method to explore the interpersonal

relationship outlooks of African American adult offspring of a parent with a mental illness. The researcher could explore the influence that a therapeutic intervention approach (e.g., attachment-based therapy, mentalization-based therapy, cognitive-behavioral therapy, psychodynamic psychotherapy, interpersonal psychotherapy) has on the interpersonal relationship perspectives of African American adults who were raised by a parent with mental illness. Transferability may not be generalized to populations outside of African American adults who have a parent with mental illness.

## Implications for Social Change

Promoting discussions about mental and emotional health, reconstructing positive narratives around mental health treatment seeking, and encouraging healthy relationship building skills can avert the adverse influences that parental mental illness can have on African American female offspring who pursue meaningful relationships. It is essential that African American women recognize the influence that maternal mental illness like maternal BPD can have on their mother-daughter relationships and subsequently on their interpersonal relationship dynamics and abilities. Findings from this study could extend empirical-based research evidence to human services providers, social services workers, counselors and clinicians about the harmful impact that maternal mental illness like maternal BPD can have on interpersonal relationship outcomes for African American female offspring. Therapists and mental health professionals could utilize attachment-based therapy interventions in the event that they encounter African American female clients who (a) struggle with forming healthy attachments as a result of maternal

deprivation, or (b) have difficulty establishing meaningful relationships due to disoriented mother-daughter attachment experiences.

African American mother-daughter attachment experiences disrupted by maternal BPD must be acknowledged in psychiatric literature and family studies. The presence of this phenomenon in mental health literature could encourage therapeutic professionals to address faulty attachment patterns due to disorganized attachment histories underlined by maternal mental illness. My implication for social change is to generate and disseminate information to therapists and mental health professionals in order to enlighten African American women to the impact that their negative maternal attachment experiences may have on their current issues with attachment and sustaining close relationships. Furthermore, mental health processionals can promote attachment-based therapy and interpersonal psychotherapy seeking along with restorative relationship practices in order to encourage healthy interpersonal and intrapersonal outcomes for African American women who may have insecure attachment orientations as a result of having a mother with BPD.

Results from this study could additionally help therapists and counselors who are familiar with the culturally sensitive therapeutic approach to understand how maternal BPD can impact later adult attachment patterns in African American women. Further social change could occur by promoting awareness of the impact of BPD on African American women who have mothers with the disorder. This social change implication could be particularly enlightening for African American women who struggle with

interpersonal relationship attachment as a result of their negative mother-daughter attachment experiences.

## Conclusion

Parental mental illness can give meaning to behavioral and interactional patterns that may result in parent-child disorganized attachment. Moreover, empirical evidence supports the interconnected relationship of human attachment with neurobiology, affect and behavioral regulation, interpersonal management and individual growth. The purpose of this qualitative, transcendental phenomenological study was to explore how the experiences of being raised by a mother with BPD affected subsequent adult attachments for African American women. Exploring the accounts of African American women who were raised by a mother with BPD and how their disordered attachment experiences impacted their adult attachment patterns, behaviors and outlooks has provided valuable insights and contributed to further knowledge in research on psychosocial outcomes for offspring of mothers who have BPD. Findings from this study could also contribute to BPD awareness in the African American community, provide a cultural perspective on the impact of BPD, and possibly help to diminish stigmas surrounding mental illness and mental health treatment seeking in the African American community. Therapeutic support that aims to address insecure attachments in African American women who have mothers with BPD is crucial for helping African American adult daughters develop the healthy relationship, attachment and bonding skills needed to pursue and establish securely attached meaningful relationships.

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Appendix A: Permission Letter for Participant Recruitment

Dear _____,

My name is Elizabeth U. Onyeali, and I am a graduate student at Walden University, pursuing a Ph.D. in Human Services with a specialization in Family Studies and Intervention Strategies. As a member of this group, I would like to ask you to share this study with the members of this group, or gain your permission to notify group members of my doctoral research study.

The purpose of this qualitative study is to explore adult attachment for African American women whose mothers have borderline personality disorder. Qualifying participants for this study must be an African American, female, be between 18 and 45 years of age, and have a mother with a clinical diagnosis of borderline personality disorder. Findings from this study could aid human services professionals, psychologists, psychotherapists, and other mental health professionals and organizations in understanding how mothers diagnosed with an Axis II Cluster B emotion dysregulation disorder like BPD affects the attachment patterns and relationships experiences of their adult daughters.

The time frame for this research study will be **June 7, 2019** through **June 4, 2020**. Willing participants are invited to partake in an open-ended, in-person or telephone 30 to 60 minute interview. Prior to the interview, participants will be asked to answer pre-screening study participant questions.

Participant interviews will be audio-recorded and transcribed, in which they will have the opportunity to review and check the transcription for accuracy. To protect participant identity, **I will not utilize their names** but will address each interviewee as "Participant" along with an accompanying number as a pseudonym in their place (e.g., Participant 1, Participant 2, Participant 3, etc.). Participation in this doctoral research study is entirely voluntary. If study respondents decide not to participate, they have the option to do so with no negative consequences. Furthermore, respondents may choose to cease participating in this research study at any time. Once more, no negative consequences will occur if they choose to discontinue their participation.

If you or your staff has any questions or concerns, please call me at **XXX-XXX-XXXX** or email me at **elizabeth.onyeali@waldenu.edu**. Thank you and I look forward to hearing from you. The Walden University IRB approval number for this study is **06-05-19-0465129.**

Sincerely,
Elizabeth U. Onyeali, MPhil, MA
Research Study Principal Investigator
Ph.D. Candidate

Appendix B: Letter of Cooperation

Dear Ms. Onyeali,

Thank you for providing the information we requested. I apologize for my delay in getting back to you.

We have reviewed the study proposal and objectives and would like work with you and Walden University to host this worthwhile study. We have members who may fit the respondent profile and would likely be interested in participating. We will create a professional account for you, and post your study on the Parent, Sibling and In-Law board, and notify you as soon as this is done.

We thank you for this opportunity. If there is anything I can do to help, please let me know.

XXXXXX
Executive Director

Appendix C: Study Invitation E-mail/Flyer/Online Forum Post

**Would you like to share your story about having an African American mother with borderline personality disorder?**

**Recruiting Participants for a Research Study Titled:**

**"Adult Attachment For African American Women Who Have Mothers With Borderline Personality Disorder"**

The purpose of this study is to explore the mother-daughter attachment experiences of African American women whose mothers have borderline personality disorder and gain insight into how African American mothers with BPD directly influenced how their adult daughters view and form close relationships.

This research project is part of a dissertation study conducted by Elizabeth Uchechi Onyeali, a Walden University doctoral candidate. Findings from this study could aid human services professionals, psychologists, psychotherapists, and other mental health professionals and organizations in understanding how mothers diagnosed with an Axis II Cluster B emotion dysregulation disorder like BPD affects the attachment patterns and relationships experiences of their adult daughters.

**Eligibility to Participate**

- Be an African American woman between 18 and 45 years of age
- Have or had a mother who has been diagnosed with borderline personality disorder by a medical professional **AND/OR** you are an African American women seeking support from BPD-specific online or social media support groups
- Be fluent in English
- Be a resident of any part of the United States of America
- Be willing to participate in an audio-recorded in-person or telephone interview between 30 and 60 minutes.

**All information will be confidential and will be used only for the purposes of this study.** As a token of appreciation for participating in this study, you will be given your choice of a $10 Starbucks, Target or Amazon e-Gift card upon completing the study.

**For more information contact:**

Elizabeth Onyeali at **elizabeth.onyeali@waldenu.edu**, or call or text Elizabeth Onyeali at **XXX-XXX-XXXX** two weeks from the date of this letter. The Walden University IRB Approval Number for this study is **06-05-19-0465129** and it expires on **June 4, 2020**
Thank you.

# Appendix D: Interview Questions

1. How did you find out that your mother had borderline personality disorder (BPD)?
2. What was your age when you learned of her diagnosis?
3. What were your thoughts about your mother's diagnosis?
4. How did you feel about your mother's diagnosis?
5. How did your relationship with your mother change since you learned of her BPD diagnosis?
6. How did your mother's diagnosis of borderline personality disorder affect your ability to bond with her?
7. Describe your current relationship with your mother.
8. What is your definition of a close relationship?
9. Can you explain how your attachment and bonding experiences with your mother influenced your personal ability to form close relationships with others?
10. How have your experiences with your mother who has BPD affected your knowledge and understanding of mental health?
11. What information would you like to share with others on how having a mother with BPD affects a person's outlook on relationships?
12. Is there anything else that you would like to share about your relationship and attachment experiences as an African American woman who has a mother with BPD?

Appendix E: Member Checking E-mail

Subject: ***(P#____) Interview Transcription for Critique/Approval*** **-Member Checking**

Dear Study Participant,

I want to once again thank you kindly for participating in this research study. As a participant of this study, I invite you to verify the accuracy of the interview data that you provided through a process known as member checking. (See attached for member checking directions).

Attached is a copy of your audio-recorded interview in written form. Please refer to the member checking guidelines within the document in order to ensure that your experiences are translated and portrayed to your highest satisfaction.

Once you have conducted a complete overview of your interview, please email the edited/approved copy back to me at **elizabeth.onyeali@waldenu.edu**. You can also **mail** a copy of this document to me upon your request for a **prepaid self-addressed envelope.**

Once this study is completed, you will be emailed or mailed a 1-2 page summary of the study findings.

Sincerely,

Elizabeth Onyeali, MPhil, MA
PhD Candidate

**1) Study Participant Reviewing Researcher's Understandings of Participant Data**

- You will receive an email/letter entitled "***(P#____) Interview for Critique/Approval***". This email/letter will contain a researcher-transcribed version of your audio-recorded interview and you will be given the chance to review your interview as the researcher has transcribed it.

**2) Study Participant Approval of Researcher Explanations Regarding Experiences**

- Once you have reviewed your transcribed interview, as a participant of this study, you will be given the opportunity to approve or correct any part of the interview that you feel needs mending or retracting.

**3) Study Participant on Making Corrections to Researcher's Transcription of Data**

- If there are any corrections to be made to transcription/translation of the interview, please feel free to make any corrections, distinguishable by your use of a different color font.

**Returning Study Participant Approval/Corrections Back to Researcher**

- Please feel free to send me back your approved interview transcription via email to **elizabeth.onyeali@waldenu.edu**.

Sincerely,

Elizabeth Onyeali, MPhil, MA
PhD Candidate

Appendix F: Certificate of Completion from the National Institutes of Health Extramural Research Office

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Elizabeth Onyeali** successfully completed the NIH Web-based training course "Protecting Human Research Participants."

**Date of Completion**: 05/21/2018

**Certification Number**: 2825572

NIH National Institutes of Health
Office of Extramural Research

Appendix G: Counseling Resources for Participants

**Online Resources**

1) National Education Alliance for Borderline Personality Disorder: The Family Connections Program

- Family Connections is a 12-week course that meets weekly to provide education, skills training, and support for those who are in a relationship with someone who has BPD. Focusing on issues that are specific to BPD, the Family Connection course is hosted in a community setting and led by trained group leaders who are usually family members of relatives with BPD. https://www.borderlinepersonalitydisorder.org/family-connections/

2) NEABPD: Family TeleConnections (TLC)

- National Education Alliance for Borderline Personality Disorder (NEABPD)'s Family TeleConnections (TLC) offers families across the country to participate in an organized virtual group to meet together for weekly teleconferences. Family TeleConnections (TLC) also offers opportunities to network though email and online discussion groups. Please visit https://www.borderlinepersonalitydisorder.org/family-connections/ to learn more.

**In-Person Resources**

1) National Alliance on Mental Illness: Family-to-Family Education Program

- Family-to-Family Education Program is a free 12-week course for family caregivers of those with mental disorders.
- Website: https://www.nami.org/Find-Support/NAMI-Programs/NAMI-Family-to-Family
- To find a NAMI Face-to-Face class near you: https://www.nami.org/Local-NAMI/Programs?classkey=a1x36000003TN9YAAW
- To start a class in your location: https://www.nami.org/Find-Your-Local-NAMI
- NAMI Helpline: 1-800-950-NAMI
- Email: info@nami.org
- Hours: Monday-Friday10:00am-6:00pm EST
- For Help in a Crisis, text "NAMI" to 741741

2) Insight Behavioral Health Centers

- Insight Behavioral Health Centers offer mood, anxiety & trauma programs that offer relief from harmful behaviors through mindfulness-based therapies.
- Psychiatrists, medical doctors, psychologists, mental health counselors, individual, group and family therapists, yoga therapists, art therapists, nurses, and patient support staff work with you to create a customized treatment plan, including tools and behavioral change modifications to help you cope with and overcome your mood disorder These nationally recognized specialists are dedicated to collaborating closely with you and your families to meet your unique recovery needs.
- Available locations: Illinois, Texas, California, Ohio, and Washington
- Website: https://www.insightbhc.com/info/mood-anxiety-treatment
- To schedule a free expert consultation: 1-877-304-1218
- To speak to a Master-Level Clinician: 1-877-711-18

**In-Person and Online**

1) Mental Health America Affiliate Resource Center (MHA)

- MHA Affiliate Resource Center is the nation's leading community-based nonprofit dedicated to addressing the needs of those living with mental illness and to promoting the overall mental health of all Americans. MHA offers prevention services for all, early identification and intervention for those at risk, integrated care, services, and supports for those who need it, with recovery as the goal. Much of the current work done by MHA is guided by the Before Stage 4 *(B4Stage4*) philosophy; that mental health conditions should be treated long before they reach the most critical points in the disease process.
- Website: https://arc.mentalhealthamerica.net/
- Sign up for MHA's online community by mailing list: http://www.mentalhealthamerica.net/
- To find a local affiliate: https://arc.mentalhealthamerica.net/
- Phone: 708-684-7722

**Books**

1) Surviving a Borderline Parent: How to Heal Your Childhood Wounds and Build Trust, Boundaries, and Self-Esteem by Kimberlee Roth
2) Stop Walking on Eggshells-Taking Your Life Back When Someone You Care About has Borderline Personality Disorder by Paul T. Mason, MS and Randi Kreger
3) I Hate You - Don't Leave Me: Understanding the Borderline Personality by Hal Straus and Jerold Jay Kreisman
4) Coping with Critical, Demanding, and Dysfunctional Parents: Powerful Strategies to Help Adult Children Maintain Boundaries and Stay Sane by David M Allen, MD
5) Understanding and Loving a Person with Borderline Personality Disorder: Biblical and Practical Wisdom to Build Empathy, Preserve Boundaries, and Show Compassion by Arterburn M. Stephen and Robert Wise
6) Adult Children Secrets of Dysfunctional Families: The Secrets of Dysfunctional Families by John C. Friel, Ph.D, and Linda D. Friel, M.A.
7) Missing: Coming to Terms with a Borderline Mother by Kathy Ewing
8) Understanding the Borderline Mother: Helping Her Children Transcend the Intense, Unpredictable, and Volatile Relationship by Christine Ann Lawson
9) Daughter Detox: Recovering from An Unloving Mother and reclaiming your life by Peg Streep
10) Toxic Parents: Overcoming Their Hurtful Legacy and Reclaiming Your Life by Susan Forward and Craig Buck
11) Mean Mothers: Overcoming the Legacy of Hurt by Peg Streep
12) Borderline Personality: A Scriptural Perspective by Cathy Wiseman
13) Borderline Personality Disorder: Understanding Borderline Personality Disorder, and How It Can Be Managed, Treated, and Improved by Ross Wilson
14) Talking to a Loved One with Borderline Personality Disorder: Communication Skills to Manage Intense Emotions, Set Boundaries, and Reduce Conflict by Jerold J. Kreisman MD.
15) Stop Caretaking the Borderline or Narcissist: How to End the Drama and Get On with Life by Margalis Fjelstad
16) When Your Mother Has Borderline Personality Disorder: A Guide for Adult Children by Daniel S. Lobel PhD