Rosenbach • Buck-Horstkotte • Renneberg

Parenting Skills for Mothers with Borderline Personality Disorder:

A Group Training

Imprint

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Preface

Initially, the idea for this training program arose from clinical experiences working with women diagnosed with BPD who had small children. Whereas the treatment of BPD has been improved continuously in the last decades, the challenges related to parenting and difficulties of mothers with BPD have not been systematically addressed.

Dysfunctional parenting is a risk factor for the development of mental disorders. Mothers with BPD are often unable to recognize and/or respond (to) their children's needs, are inconsistent in their parenting styles and have difficulties in setting adequate limits. Difficulties in emotion regulation are a core feature of BPD and constitute a severe problem for parenting. As a result, children of mothers with BPD are often missing adequate role models and orientation – and are at high risk to develop dysfunctional behavior patterns themselves. The training aims to support mothers with BPD to develop positive parenting strategies and thereby to interrupt the intergenerational transmission of dysfunctional emotion regulation strategies.

In the development of the training program, we combined our clinical experiences (Sigrid Buck-Horstkotte and Johanna Gabriel) and our scientific knowledge (Charlotte Rosenbach and Babette Renneberg) to support mothers with Borderline Personality Disorder (BPD) raise their children. In 2015, the German version of this training manual was published (Buck-Horstkotte et al. "Borderline und Mutter sein"). Since then, the training has been conducted in a variety of outpatient as well as inpatient facilities, practitioners as well as researchers have asked for workshops and trainings, and research projects have been initialized. The demand for an English version of the training has been emphasized in various settings. In the beginning, we conducted several groups to test each session regarding its feasibility and to find the best order of the different topics. We continuously adapted the program and took the feedback of participating mothers into account. The present manual with 12 sessions is the result of this process. Additionally, in this updated and adapted English version, we incorporated small changes, e.g. in the homework sheets. The training is conceptualized for mothers with small children (0-6 years) because early support enhances the chance to improve parenting strategies and to prevent maladaptive child development. Most of the patients with BPD living together with their children are female. We therefore address this training for groups of mothers with BPD and refer to "mothers" rather than "parents". We do not exclude the possibility that fathers with BPD can benefit from this training, too.

Special thanks goes to all mothers that participated in the training and supported us with their feedback. We would like to thank all our colleagues that supported us through the different stages of development, testing, adaption and translation. Without their constructive feedback and practical help, we would not have been able to publish this manual. Special thanks go to Johanna Gabriel and Claudia Kertzscher for their commitment in the development of the training. We like to thank Eliora Porter for her essential editorial contributions to the English translation, Marina Benoit for her conscientious proofreading and Nora Wendt for the formatting and the final layout.

Our special thanks go to Lukasz Buda for his illustrations!

Our aim with this book is to support professionals working with mothers with BPD, the affected mothers and their children.

Berlin, January 2020

Charlotte Rosenbach, Sigrid Buck-Horstkotte, and Babette Renneberg

1   Background

1.1 Introduction

Raising children is both pleasure and challenge at the same time. In the first years of parenting, parents often struggle with major adjustments in their lives: they suffer from sleep deprivation, are faced with a change of life focus, must organize their daily routine according to the children's needs and so forth. Despite their overwhelming joy, young parents are often confronted with greater challenges than usual. If one or both of the parents have been diagnosed with a Borderline Personality Disorder, being a parent can even be more challenging.

Borderline and parenting. The daily life of women with Borderline Personality Disorder (BPD) is characterized by recurring and frequent changes in mood, self-image, and identity. In stressful situations, these women tend to react with impulsive or self-harming behavior, easily lose their temper, or engage in excessively self-damaging behavior (e.g., drinking, drug use). At the same time, individuals with BPD have difficulties engaging in and especially maintaining stable relationships. This "stable instability" of interpersonal and emotional problems affects all daily interactions, including the parents' relationship with their infant(s). The caregiver's stability and dependability are crucial for a healthy development of children. Thus, women with BPD are extremely challenged when raising a child.

> **Case example**
>
> As a toddler, Jenny often was locked in by her alcohol-dependent parents, alone and without food, until she was placed in a foster family. From early childhood, Jenny suffered from extreme tantrums. Her rage was directed against objects, other people and herself. When she was 24, during a stay in a psychiatric day unit, she met her boyfriend and accidentally got pregnant after a short time. An abortion was no option for Jenny, but she was very scared that she might hurt her child because of her uncontrolled rage. She often thought, "I can't endure my son's crying and his permanent demands no more." However, she did not want to ask the youth protection office for help, as she was afraid that they might take her son away from her. She started a therapy, determined to get control over her problems and to learn to be a good mother.

Children's needs. There is general agreement on what children need for a healthy development. Three categories of needs can be differentiated: vital needs (food, body care, clothing, shelter, security and harm protection), social needs (love, comfort, acknowledgement, attachment), and the need for competence and self-determination (education, activity, self-esteem). The smaller children are, the stronger they depend on their caregivers for the satisfaction of their needs.

     Although children's rights are specified and guaranteed by laws and regulations, parents are mostly responsible for the satisfaction of these needs. It is their duty to generate an adequate, promoting and healthy environment for the children's development. Different (educational)

institutions (e.g. daycare) can have supportive, compensatory and/or controlling functions. If parents aren't capable to address their children's needs because of a mental disorder, this can lead to severe negative consequences for the development of their children (e.g. Breaux, Harvey, & Lugo-Candelas, 2014).

New opportunities and challenges. Eventually children may help parents to see their own life story from a new perspective and – maybe for the first time in their lives – to have a feeling of belonging and responsibility. This in turn can lead to a new sense of identity and stability. Many mothers with BPD know about their responsibility and would do everything to keep their children away from their mental distress and to prevent them from experiencing the same difficulties as they did. The concern about their children's well-being can therefore enhance the mothers' motivation to start a therapy and promote processes of change in their behavior.

Women who themselves did not experience safety, love, belonging and protection, often see parenthood as a way to fulfill their urgent wish for someone who belongs to them and accepts them unconditionally. These women may experience extreme closeness to their child during pregnancy and the first months of motherhood, especially when the child is quiet and not fussing.

Eventually, all children show a desire for autonomy. They have urgent needs to explore and do not consider or are even aware of their mothers' mental state. They do not support but challenge their parents. Mothers find themselves in a conflict between their claim to be a good mother and their need for peace and time for themselves. These situations often lead to a vicious circle of children's adverse behavior and maternal frustration.

Where are children located in the treatment of BPD? In the last decades, great progress has been made in the treatment of BPD, even though there still is room for improvement in therapy outcome (Stoffers, Völlm, Rücker, Timmer, Huband, & Lieb, 2012). One main goal of the treatment is to reduce suicidality and self-harming behavior and thus assure the survival and the well-being of the patient. The challenging and difficult task to help individuals with BPD to cope with their crises keep therapists busy - so that the issue of the children's well-being is often secondary.

For several reasons, mothers with BPD themselves do not speak much about their children with their therapists, neither. First, they typically focus on their most urgent issues: their suffering and crisis with conflicts in interpersonal relationships or at work. Problems in the interaction with the child might not appear to be urgent enough. Secondly, shame and fear play an important role when considering speaking openly about the neglect or abuse of their children. The fear of being stigmatized and of losing child custody often leads to a cautious and non-help-seeking behavior.

Therefore, mothers with BPD and their children often have first contact with the welfare system when it might already be too late for an effective prevention: in situations of acute endangerment of the child's welfare or in severe crises. However, even when mothers succeed to contact the welfare system in time, the knowledge about BPD on the institutional side is often insufficient. This might lead to a lack of adequate support and in turn to a growing distrust on the mothers' side towards institutions that are responsible for the children.

Nevertheless, mothers often perceive psychotherapists in a different light than institutions or official personnel, as issues addressed in therapy underlie professional secrecy.

Therefore, therapists should encourage mothers with BPD to openly speak about their problems with their children and therefore find ways to protect and support their children despite their own difficulties. The experience of not being devaluated and of finding support and understanding helps them to accept own shortcomings.

The present book. Aim of this book is to raise awareness of the difficulties and chances when working with mothers with BPD and to provide guidance for therapists and counselors.

The book is divided in two parts: a theoretical part providing background knowledge regarding borderline symptoms and their consequences for parenting based on current empirical research, and a practical part comprising the training manual. In the appendix, all working sheets and information for trainers are provided.

1.2 Theoretical background

"I got diagnosed with borderline personality disorder. It hurts me to see my children suffer. I do not want them to make the same experiences I did. I'd love to be a perfect mother."

1.2.1 Borderline symptoms and consequences for parenting

Symptoms. BPD is characterized by a stable pattern of instability in relationships, in self-image and in emotions. The fear of being rejected or abandoned combined with difficulties to maintain close relationships lead to severe, interpersonal problems. A chronic feeling of emptiness and a distinct affective instability often result in self-destructive behavior, e.g. alcohol and drug abuse, unprotected sexual intercourse or bulimic/binge eating behavior. Suicidal or self-harming behavior can also be part of the BPD. In addition, mothers with BPD often have low social support, difficult relationships and/or financial difficulties to cope with and may be unable of handling their daily routine.

Prevalence. There are different data regarding the prevalence rates of BPD. Point prevalence ranges between 0.5-3.9% in the general population (Lenzenweger, 2008). An US-American study reports a lifetime prevalence of 5.9 percent (Grant et al., 2008). It can be assumed that in western societies 50-80 percent of BPD patients are eventually in psychiatric or psychotherapeutic treatment (Stiglmayr, 2011). These numbers indicate that BPD is a common mental disorder and that most of the affected people seek help and support in the health care system. Mainly female BPD patients are seen in psychiatric and psychotherapeutic institutions, whereas it is presumed that the sex ratio is more balanced in the general population (Belsky et al., 2012) and in forensic settings (e.g. Robitaille et al., 2017).

Borderline symptoms often start in early adolescence (Zanarini, Frankenburg, Khera, & Bleichmar, 2001). In adulthood, with increasing age, prevalence rates decrease (from the age of approx. 44 years; Grant et al., 2008). Epidemiological data indicate that the majority of BPD patients are in childbearing age. Unfortunately, there are no valid statistics regarding the number of women with BPD who have children. Consistent with Plass and Wiegand-Grefe (2012), clinicians estimate that approximately 30% of female patients with BPD who are in inpatient treatment have children.

Comorbidity and consequences for the social environment. Rarely do patients with BPD

just have this single diagnosis. Usually, they suffer from additional diagnoses like depression, anxiety disorders, substance use disorders or other personality disorders. The course of BPD is associated with frequent crises and in-patient (emergency) stays. Both, single BPD symptoms as well as associated factors of comorbid disorders can have a negative impact on the mental health of children of parents with BPD.

To better understand the effect of borderline symptoms on the parenting behavior and the development of their children, the diagnostic criteria of BPD according to DSM-5 (American Psychiatric Association, 2015) are described and related to possible consequences for the children.

Diagnostic criteria for BPD according to DSM-5

To diagnose BPD, five of the following nine criteria have to be met:

(1) **Frantic efforts to avoid real or imagined abandonment.** To avoid being alone in life, women with BPD tend to move from one romantic relationship to the other, frequently change partners and may cling to dysfunctional relationships. Sticking to dysfunctional relationships can have the effect that children are not appropriately protected (e.g. from a violent partner). Additionally, mothers with BPD might also cling to their children and show patterns of parentification. This means that children take care of their mothers by comforting or soothing them, by distracting them or by giving structure and stability. Role reversal and clinging behavior hinder mothers to see their child as individual human being. Apart from the fact that children mostly are overburdened with these tasks, they also can be restricted in their autonomy development.

(2) **A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.** These behavior patterns go along with extreme changes between intimate closeness and interpersonal distance. Therefore, the relationship to a child can also be characterized by extremely ambivalent bonding. Depending on the mothers' mood, the same behavior of a child can lead to aversive, rewarding or indifferent reactions. A child experiences his mother's behavior as unpredictable and can't make a consistent connection between the own behavior and maternal reactions. Therefore, the acquisition of socially competent behavior is hindered. The reduced predictability of maternal behavior additionally enhances the risk of anxiety development in children.

(3) **Identity disturbance: markedly and persistently unstable self-image or sense of self.** Identity disturbances often include the disturbance of the identity as a mother. Women with BPD get into role diffusion and can't develop stable feelings for the child and for their role as mother. They oscillate between "motherhood is great" and "I don't want to be a mother". Due to their mothers' instability, children in turn can't find a reliable and orientating counterpart.

(4) **Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).** These forms of impulsivity can confront the child with unpredictable, inappropriate, dangerous and aggressive maternal behavior. Additionally, the child's essential needs might be neglected during the impulsive behavior excess of the mother.

(5) **Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.** Suicidal behavior, gestures, or threats, as well as self-mutilating behavior on the part of the mother can endanger the child and cause the child to feel panic, anxiety, a sense of being overwhelmed and massive feelings of guilt.

(6) **Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).** Extreme mood swings with permanent changes in behavior and communication patterns might provoke disorientation, uncertainty and the lack of emotional support in children. Therefore, an adequate model of emotional regulation is missing and children can't develop emotion regulation skills themselves.

(7) **Chronic feelings of emptiness.** Chronic feelings of emptiness bear severe suffering for mothers in terms of isolation and loneliness. The mother is no longer capable to react to the child and to provide feedback. The child fails in reaching the mother emotionally – or only succeeds with great effort (e.g. extreme behavior). This can elicit in the child panic and strong feelings of powerlessness and of being lost.

(8) **Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).** A mother who can't control her anger will most likely hurt her child emotionally and / or physically. Even if not the children themselves but others (e.g. partners, siblings) are the victims of such violence, this can have similar, eventually equally traumatizing effects on the child.

(9) **Transient, stress-related paranoid ideation or severe dissociative symptoms.** In this case, the child is confronted with the mother's loss of reality. Next to very specific risks, the child can get deeply disturbed and develop great anxiety, especially when the child is part of the mother's paranoid system.

It is important to note that the listed criteria of BPD may not necessarily lead to negative consequences for the child. However, the child is at a greater risk of developing negative attachment styles, anxiety and other psychopathological symptoms later on. Current research in this regard is presented in the next section.

1.2.2 Etiological aspects of Borderline Personality Disorder and their meaning for motherhood

Mental disorders as risk factors. Parental mental disorders are one risk factor for mental disorders in their children (Breaux, Harvey, & Lugo-Candelas, 2014). The development of mental disorders is a complex combination of biological (e.g. genetic), social and psychological factors. Especially the interaction between a genetic predisposition and adverse environmental conditions promotes the development of mental distress. Core symptoms of BPD such as emotional instability and impulsivity often appear in children of individuals with BPD. First-degree relatives have a four to 20 times higher risk of a borderline diagnosis (Barnow, Spitzer, Grabe, Kessler, & Freyberger, 2006). Other studies also show a high familial incidence of BPD (e.g. Barnow et al., 2013; Gunderson, Zanarini, Choi-Kain, Mitchell, Jang, & Hudson, 2011). Estimations differ as to the proportion of genetic and epigenetic factors in the development of BPD. A twin study showed a genetic factor of 69 percent (Torgersen, Myers,

Reichborn-Kjennerud, Roysamb, Kubarych, & Kendler, 2012). Another study investigating the heritability of single borderline symptoms reported 42 percent (Distel et al., 2008). Therefore, approximately half of the explained variance in borderline symptomatology is due to genetic factors. These findings do not only apply to BPD: large-scaled prospective longitudinal studies showed that individuals with a genetic vulnerability for mental disorders more often develop a major depression after childhood abuse than individuals without genetic vulnerability who experienced childhood abuse (Caspi et al., 2003).

Genes and family. In a British prospective longitudinal study (Environmental Risk Longitudinal Study, E-Risk), Belsky et al. (2012) investigated the course of borderline specific symptoms in a sample of 1116 twin couples from age five to 12. Taken together, results prove the diathesis-stress model for the development of BPD (Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004). Genetic and environmental factors individually and especially through their interaction contribute to the development of BPD. Belsky and colleagues (2012) demonstrated that children who were abused physically or whose mothers expressed more negative emotions ("expressed emotions") showed more borderline specific behavior than children did who were treated less roughly. Furthermore, children with relatives with mental disorders were at even higher risk for the development of borderline specific behavior patterns. These studies demonstrate that borderline symptoms exist in high familial co-occurrence. Genetic factors contribute to the familial transmission of BPD as well as parental behavior.

Attachment. Women with BPD often made negative experiences with their primary caregivers and experienced severe traumatization. According to Levy (2005), these experiences might contribute to their current problems and result in a disorganized attachment style (see attachment styles, Bowlby, 1982). This attachment style in turn influences their behavior and leads to severe problems in building and maintaining relationships.

Invalidation. In Linehan's theory of the borderline etiological model (1993) the invalidating environment plays a crucial role. Invalidating behavior from significant others is characterized by unpredictable and inappropriate extreme reactions to the child's statements. The child's expressions are not validated, i.e. approved, but on the contrary are trivialized or punished. Consequently, the child does not learn how to manage his emotions effectively, which may lead to more emotion dysregulation down the road.

The mentioned etiological aspects of BPD – genetic predisposition, maternal mental disorder, attachment and invalidation – are of high significance for the parenting behavior of mothers with BPD and can help to understand the dysfunctional attitudes and behaviors mothers with BPD show towards their children.

Parenting behavior of mothers with BPD. Several studies showed various difficulties in parenting of mothers with BPD (Eyden, Winsper, Wolke, Broome, & MacCallum, 2016; Florange & Herpertz, 2019; Petfield, Startup, Droscher, & Cartwright-Hatton, 2015; Stepp, Whalen, Pilkonis, Hipwell, & Levine, 2012). Often, the mothers can't adequately interpret their children's mental state (Marcoux, Bernier, Séguin, Boike-Armerding, & Lyons-Ruth, 2017; Schacht, Hammond, Marks, Wood, & Conroy, 2013), and emotional states (Elliot et al., 2014), and therefore show insensitive and inappropriate reactions to their infant's needs (Newman,

Stevenson, Bergman, & Boyce, 2007). Additionally, the estimation of age-specific parenting strategies are often impaired (Stepp et al., 2012).

Compared to healthy mothers, mothers with BPD show increased hostility (Kluczniok et al., 2018) more affective dysregulation as well as more critical and intrusive behaviors, role confusion, and frightened/frightening behaviors when communicating with their children (Hobson, Patrick, Hobson, Crandell, Bronfman, & Lyons-Ruth, 2009; Macfie, Kurdziel, Mahan, & Kors, 2017).

They perceive more negative emotions in their infants than objectifiable and show more punitive and trivializing (invalidating) parenting behaviors in response (Kiel, Viana, Tull, & Gratz, 2017). Thus, maternal emotion regulation difficulties play a reinforcing role.

At the same time, mothers with BPD are less satisfied, feel more incompetent and stressed regarding their parental abilities compared with mothers without mental disorders (Newman et al., 2007) and misjudge their impact on their infants' emotions and behavior (Ramsauer, Mühlhan, Müller, & Schulte-Markwort, 2016; Elliot et al., 2014). When looking at maternal attachment styles, mothers with BPD show more insecure, preoccupied and unresolved attachment patterns than healthy mothers (Macfie, Swan, Fitzpatrick, Watkins, & Rivas, 2014).

Two studies showed a direct link of parental BPD to a greater risk of child maltreatment (Hiraoka, Crouch, Reo, Wagner, Milner, & Skowronski, 2016; Dittrich et al., 2018).

Additionally, environmental factors play an important role in the children's development. Children of mothers with BPD often live in unstable environments (frequent moves, change of schools, frequently changing partners, substance abuse, in-patient treatment and long absences or suicide attempts of the mother). Thus, they experience little safety, stability or sustainability (Feldman, Zelkowitz, Weiss, Vogel, Heyman, & Paris, 1995). This unreliability and unpredictability can lead to fears and worries in the children.

1.2.3 Empirical findings regarding children of mothers with BPD

When negative familial interaction patterns meet a genetic predisposition, the risk for the development of a mental disorder increases. A child with a "difficult temperament" makes it hard for parents to build up a good parent-child relationship. When parents react with warmth and acceptance, the risk of a mental disorder is reduced, whereas dysfunctional interaction patterns (a hostile and aggressive attitude, parental selfishness) enhance the risk. An aggressive attitude and a high parental self-centeredness (Berg-Nielsen & Wiechström, 2012) enhance the risk of emotional and behavior problems of children as well as an overprotective or rejecting parenting behavior does (Reinelt, Stopsack, Aldinger, Ulrich, Grabe, & Barnow, 2014). Compared with children of healthy mothers, children of mothers with BPD have a much higher risk for mental distress and behavior disorders (see Barnow et al., 2013; Barnow et al., 2006; Herr, Hammen, & Brennan, 2008).

Infants and toddlers. From the age of 3 to 36 months, children of mothers with BPD are less attentive and interested in the interaction with their mothers than are children of healthy mothers (Newman et al., 2007). Crandell, Patrick, and Hobson (2003) conducted a study with two-month-old children and their mothers using the still-face-paradigm (the mother interrupts the interaction with the child and remains motionless). Children of mothers with BPD looked

away more often and showed more dazed and fixed gazes than children of healthy mothers did. Additionally, children of mothers with BPD showed less positive affect than children of healthy mothers. The authors interpret this reaction as emotion dysregulation in a stressful interpersonal situation. Additionally, it took children of mothers with BPD longer to recover from the situation. Ten months later the same children were examined again and 80% of the children of mothers with BPD showed disorganized attachment styles.

Already at an early stage, children of mothers with BPD express less positive phonation and more negative affect than infants of mothers with no psychopathology (Apter et al., 2016) and show disturbed levels of fear expression (Whalen, Kiel, Tull, Latzman, & Gratz, 2015).

Pre- and schoolchildren. Macfie and Swan (2009) examined 4- to 7-year-old children of mothers with BPD and children of healthy mothers in an imaginary familial stress situation. In children of mothers with BPD, the authors found lower emotion regulation, and a higher tendency to have fantasies and traumatic contents in their narratives than in the control group. Additionally, they show more fear of abandonment (Macfie et al., 2014) and parent-child role reversal (Macfie et al., 2017). In an interaction task, they endured higher levels of maltreatment (Trupe, Macfie, Skadberg, & Kurdziel, 2018) compared to children of a healthy control group. Additionally, incoherent behavior patterns (room is cleaned up, then chaos is created again) and a shameful self-representation (child says in narratives "I am bad") was observed in children of mothers with BPD.

Disruptive behavior, Attention Deficit/Hyperactivity Disorder (ADHD) and borderline symptoms are more prevalent in children of mothers with BPD than in children of healthy mothers (Weiss, Zelkowitz, Feldman, Vogel, Heyman, & Paris, 1996; Frankel-Waldheter, Macfie, Strimpfel, & Watkins, 2015).

One study compared children of mothers with depression and children of mothers with depression and BPD (Abela, Hankin, Haigh, Adams, Vinokuroff, & Trayhern, 2005). The latter group reported more symptoms of depression, ruminated more, had a tendency to negative attribution and self-devaluation, showed unsecure attachment styles and partially sought more acknowledgement than did children of mothers with only a depressive disorder.

Adolescence. Barnow et al. (2006) compared 11-18-year-old children of mothers with BPD with children of mothers without mental disorders and found more attention deficits, delinquency and aggression as well as elevated anxiety and depression scores and lower self-esteem in adolescents with mothers with BPD. Psychosocial problems, low self-perception, anxious attachment, chronic stress perception in the interaction with the mother and maternal hostility were observed more frequently in children of mothers with BPD than in a sample of children with healthy mothers (Herr et al., 2008).

Conclusion. In summary, from infancy to adolescence, children of mothers with BPD have a higher risk for emotional and behavioral problems than children of healthy mothers. Whereas the maternal influence is strong in early childhood, peers and the social context gain influence with age. Nevertheless, these early years are especially crucial for formative experiences and shape long-lasting ideations and schemes regarding one's own needs, identity and the formation of interpersonal relationships.

1.2.4 Resources and protective factors

Maternal resources. The development of a child who grows up with a parent with BPD depends on various factors. Apart from the risk factors described above, resources of the caregiver play an important role. Many women with BPD have a variety of qualities that are very valuable for their children: next to personal competences and resources, women with BPD can be very empathic, are emotionally open and very creative – especially in situations where others feel down. Often they know about their own difficulties and deficits and are willing to seek help (e.g. psychotherapy). If they are capable to control their impulsive-destructive behavior, they might adequately fulfill their children's needs and be good mothers. This requires the knowledge about children's needs and a realistic self-perception. Mothers with BPD can learn to act in favor of their child's well-being and against their own inappropriate behavior tendencies – and therefore make new experiences. They can also work on getting support for their children from relatives or friends.

Children's resources. Children's resources also influence their course of development. There is evidence that early acquired or inherent biological properties influence how children interact with their environment. Children with a low vulnerability seem to have a "thick skin" and are less sensitive to injuries; they show "resilience".

Furthermore, the child's temperament plays a role. It is conceivable that content children will make other experiences in their early childhood with their caregivers than children who frequently cry and are hard to satisfy.

Additionally, it is likely that a mother with BPD (and not only she) behaves differently towards her child depending on the sex, temperament and on which preferences, strengths and difficulties the child develops.

Children growing up under difficult conditions often develop creative coping and survival strategies (Furman, 1999). This is accompanied by the possibility to make new positive experiences. Often, the quality of a traumatic event is less important compared to the appreciation and validation of the child's reaction. Being able to express pain, suffering, despair and anger without being condemned is considered a protective factor. Like a plant searching for a light beam in the dark, children are often very competent in building and maintaining helpful relationships. These are often relatives, friends, teachers or neighbors – sometimes animals, even stuffed animals or fantasy creatures – which indicate "you are not alone and you are ok as you are".

Conclusion. Taken together, there is a large variety of borderline specific behavior that can have a huge negative impact on the emotional development of a child. On the other hand, mothers with BPD have special capabilities and a high willingness to change. Therefore, taking advantage of their capabilities and their willingness to change, it is paramount to reduce the dysfunctional and enhance the functional behavior of mothers with BPD.

1.2.5 Basics of the training "Parenting Skills for Mothers with BPD"

The main goal of the newly developed training is to focus on the needs of mothers with BPD. For one thing, the training considers borderline specific difficulties in the care for and the interaction with a child; on the other hand, it conveys general knowledge and strategies of parenting. While developing the group training we considered both existing parenting programs as well as the skills training for treating borderline symptoms developed by Linehan (Linehan, 2015). Recent findings and existing parenting trainings lead to some general recommendation for interventions for mothers with BPD:

Psychoeducation. Information and psychoeducation on child development should be one main component of the program to enhance the differentiation between typical or normal behavior and atypical or abnormal behavior for different stages of age. By learning to know what can be considered as normal behavior, mothers can develop adequate expectations and better react to their children's needs. One example is: *"When my child cries, this does not automatically mean that I am a bad mother. I can comfort her and check what she needs."* Basic information on children's needs and cognitions can adjust dysfunctional assumptions and help to create a positive relationship. Additionally, it should be discussed that own experiences of inefficient and harmful educational strategies in the family of origin can be transmitted to the next generation. Consequently, own unfavorable behavior can be identified and modified.

Changes in perspective. Basic needs of children should be explained and maternal change in perspective enabled. Thereby, understanding and respect for their children and their needs are important factors. Understanding implies the idea of how the other person feels, to know the other's motives. This is often difficult with children – especially with small children – when their behavior initially does not seem comprehensible. The attitude *"I don't know what is wrong but I assume you have reasons to cry. This does not mean that I like your behavior but I will try to do my best so that we both can be content"* is essential. A higher empathy for the child makes it easier to take the child's perspective, so that a more understanding attitude can be developed.

Parenting strategies. General positive parenting strategies (to perceive and reinforce appropriate and healthy behavior) and non-violent ways of setting rules and limits (in a clear, calm, respectful and consequent manner) should be conveyed in the training.

Emotions. Mothers should be enabled to provide warmth and comfort. The child's emotional development is dependent on the emotionality in the behavior of the parents. Thereby, the parents' attitude towards emotions is crucial. A positive reaction to children's emotions supports the emotion processing and regulation as well as the development of adequate strategies (re-evaluation, problem solving). Children need support in dealing with difficult emotions, especially in stressful social situations with peers and adults. A child should not be criticized or punished for his/her emotions; nor should the child be laughed at for the expressions he uses. Such reactions from caregivers in response to expressions of emotion can lead to a suppression of emotions altogether or the development of avoidant or aggressive behavior. The main aim should be to promote the development of consistent and positive reactions to the children's emotions, even if the own maternal stress urges to avoid or to control the children's emotions.

Stress. Strategies for better emotion regulation and stress tolerance help to regulate the high tension in mothers with BPD (Linehan, 2015). Stressful situations can be handled by using adequate coping strategies. Mothers with BPD need help to gain inner distance in difficult situations and to let go of negative patterns. They need to be trained to recognize their own limits, so they can ask for advice or help and accept support.

Structure. Mothers with BPD often have difficulties in creating and maintaining a stable and structured environment. The importance of a regular and predictable routine for the child is emphasized, as well as the importance of parental surveillance and of having an overview of the child's activities and behavior patterns. Providing a stable and safe domestic environment can also promote parental self-efficacy. A structured routine additionally reduces the development of stress.

Self-care. Without learning self-care, it is difficult to stick to positive parenting strategies. To responsibly deal with own needs is a basic requirement for the own satisfaction and for successful parenting.

Mindfulness and acceptance. Mothers are often confronted with situations they cannot (yet or immediately) change (e.g. persistent crying of a child, absent partner, own limits, difficult social conditions). These facts are hard to accept - especially for women with BPD. Mindfulness and acceptance based strategies can help to approach such situations with more serenity and to concentrate on actual possibilities and necessities.

The training "Parenting Skills for Mothers and BPD". Considering all these listed aspects, the group training was developed. It addresses psychotherapists for adults, children and adolescents, therapists and counselors working in educations counseling, as well as therapists and counselors working with parents with BPD. The training can be applied in in- and outpatient facilities.

In 12 sessions, we combined psychoeducational as well as cognitive-behavioral methods and exercises. The following topics are included in the program: children's needs, stress and stress management, structure, conflict resolution, dealing with emotions, mindfulness and self-care, basic assumptions in parenting as well as the significance of the body (closeness, violence). Ideally, mothers participate in the training while they are or have completed individual treatment for the BPD symptoms.

The main goal of the group-training program is to break the vicious circle of transgenerational transmission of mental problems. The objective of the program is to support mothers with BPD to develop more positive communication strategies and to better cope with the parenting challenges motherhood involves.

2 Group training: "Parenting Skills for Mothers with Borderline Personality Disorder"

2.1 General framework of the group training program

The training is designed for a group of four to six mothers of young children (aged 0-6) and can be carried out in outpatient settings and day treatment settings, as well as assisted living communities, child guidance offices, etc. The training comprises twelve sessions of two hours each, and covers eleven modules.

To ensure the transfer of their newly learned skills into their parenting behavior, the mothers must live or regularly interact with their children for the duration of the training. If the training is to be carried out in an inpatient facility, it is essential that the mothers have the opportunity to interact with their children in everyday life.

Trainers. The training should always be conducted by two female trainers. The training is based on dialectical behavior therapy (DBT, Bohus & Wolf-Arehult, 2013; Linehan, 2015). It is therefore very helpful for the trainers to have previous experience in DBT, though this is not a requirement. However, the trainers must be familiar with the difficulties and treatment of patients with BPD, and at least one should have experience with young children.

Individual therapy. As with standard DBT, it is helpful to conduct supplementary individual therapy sessions in addition to the group work. In the individual therapy, mothers can deepen their understanding of what they have learned and adapt it to their situation, discuss their personal crises and overcome motivational obstacles. The individual and group therapists should confer throughout the group training. This exchange of information should be clear to the patients. Usually, the individual therapist and group trainer are two different people, but it is also possible for one of the trainers to additionally work in an individual therapy setting with the participants. In this case, the second group trainer should then be able to take a more impartial stance in the group sessions.

Video recordings. Taking video recordings of all group sessions has been proven to be helpful. Video recordings are the best foundation for supervision or team consultation, and serve a special function in sessions in which role-plays are recorded and discussed within the group. Initially, many participants are uncomfortable with the recordings, but they tend to accept and even appreciate them if the trainers properly explain their purpose and videotape every session. The video recordings should be mentioned explicitly in the consent form for group participation.

Preparation and admission requirements

Mothers should be screened before being accepted into the group to ensure they are not engaging in acute child endangerment. In principle, there are two kinds of child endangerment:

▶ parental actions, e.g. violence against a child
▶ parental abandonment, e.g. severe neglect of a child

Endangerment of child welfare

Signs of acute child endangerment are:

► danger to life and limb

► physical violence (causing the child physical injuries or pain)

► gross neglect of the care and nourishment of toddlers and infants (eating, drinking); gross neglect of the responsibility to protect babies and young children from potential danger

► gross emotional violence or inadequate communication (shouting at children, ignoring children, grossly misinterpreting their signals).

Even if a mother is not yet able to fully control her endangering behavior, she meets the prerequisites for group participation if she is in a protected institution, or if other caregivers or professionals ensure the protection of her child.

We assume that the mothers will have been diagnosed with and informed about their BPD in advance. If this is not the case, additional sessions are required before the group training begins.

Preliminary screening. The trainers should have a minimum of one individual session with each participant before the training begins. In this individual session, the trainers should:

► clarify the reason for participation in the group training

► inform the participant about the schedule of the training, time commitment, general framework and costs of the training

► clarify the participant's motivation to change and willingness to participate in the training (commitment)

► review and explain the group training consent form (see "Model Group Training Consent Form" in the appendix)

► inform the participants about the protection and limits of confidentiality (country and state dependent).

2.2 Structure of the training

Time structure of the sessions

Each session is divided into two 50-minute blocks with a 20-minute break in between. Before each session, the trainers should write the session's agenda on a blackboard or flip chart, and they should then present the agenda at the beginning of the session.

Next, each participant should be asked to rate her individual level of tension (see H 1c Tr), and the trainers should then lead the group in a mindfulness exercise. In case the aversive tension for a mother is too high to participate in the mindfulness exercise (>70), she should be asked what could be helpful to regulate the aversive tension.

The trainers and participants can add to or modify the mindfulness exercises (H 1b Tr) as they see fit.

Homework. In all sessions (with the exception of the first), participants should discuss the homework and their experiences with it in the first part of the session. It is advisable to divide the time such that 5-10 minutes are available for each mother, depending on the group size. An egg timer is helpful in dividing time fairly. When discussing the homework, the trainers should always first ask if the participants have read the handouts and if they have any questions or comments that should be addressed. It is essential for the participants to do their homework

in order to transfer their newly learned skills to everyday life—the mothers can only find out if alternative ways of parenting are helpful for themselves if they try them out with their children. When asked what she found particularly helpful about the homework, one participant said: *"It's really hard to do the homework regularly, but doing it is the only way that you can learn to change"* (Sellin, 2014, p. 39).

Summarizing their findings on the benefits of homework, Fehm and Helbig (2008) offer the following recommendations:

Recommendations for homework
- ► Assignments should be easy and not overly time-consuming.
- ► Assignments should build on the participants' existing strengths and resources.
- ► The relationship between homework and long-term therapeutic goals should be clear.
- ► Written materials such as notes, logs, and workbook pages should be used for the homework.
- ► All assignments should be discussed in the following session.

If the discussion of the homework takes less than 50 minutes, the break can be moved forward. After the break, the trainers should introduce the new topic for the session, usually through behavioral rehearsals and hands on activities.

Second part of the session. A new topic should be introduced by a behavioral rehearsal, roleplay or an imagination exercise. Afterwards, the group members should discuss their individual experiences with the exercise and the trainers should add theoretical information. At the end of the session, the trainers should announce the homework for the next session. Every participant should develop an individual take-home message, which summarizes the day's essential information and insights, and write it down:

"From today's session, I'll take home _____."

Additionally, the trainers can give a concise summary of the most important aspects of the session (a "take-home message" can be found at the end of the section for each session: see section 2.4.1, etc.).

Structure of the training. The training is divided into eleven thematic blocks (modules) that build upon each other. The first session serves as an orientation to introduce the subject matter, give an overview of the training and allow the group members to get to know one another. The last session serves as a summary of the topics covered over the course of training.

Materials and equipment for the group
The following materials are required:
- ► flip chart
- ► timer/egg timer
- ► video camera
- ► projector or screen for watching the video-taped role-plays
- ► folder for the participants' documents (one for each participant)
- ► reward cards and stickers
- ► various materials for behavioral rehearsals (specified in the corresponding chapters)

Reward cards. Establishing a reward system has proven to be helpful as additional motivation

for the mothers to do their homework. At the beginning of the training, the trainers distribute a reward card (HS 1) to each participant. Each participant can pick out a sticker (of which the trainers should have a sufficient supply) as reinforcement for completing the written homework and the assigned reading, respectively. Each participant can receive up to 22 stickers by the end of the training.

The trainers should distribute the stickers after the discussion of the homework and before the break. At the end of the training, the trainers can additionally distribute small rewards to mothers who earned certain amounts of stickers (these rewards can either be chosen by the participants beforehand or by the trainers as a surprise). The participants are usually amused by or pleased with the stickers; very few reject the system or judge it as "silly." Many of the mothers have only experienced punishment for misbehavior, follow the same model when raising their own children, and are convinced that a self-evident obligation like completing one's homework does not deserve a reward. The trainers should explain that rewards are an important tool when raising children, and that they are more effective than punishment when teaching new behavior to both adults and children. Thus, the participants are enabled to learn how a structured reinforcement system works, and how to operate within one.

Basic stance of the trainers

It is important for the trainers to have a validating and encouraging stance in the group. This is particularly important when discussing basic assumptions about parenting (session 10). Showing appropriate appreciation for the participants should help them improve their self-images as mothers. It is also important to help the mothers speak openly about their parenting difficulties, and avoid defensiveness if possible.

Each mother should be considered an expert on herself and her child that wishes to improve herself. The participants and trainers should meet each other on an equal footing. The trainers should not "coddle" the participants—they should directly point out the mothers' problematic behavior, and help the mothers respond to the more unpleasant facts of their situations. At the same time, the trainers should be validating and consider the feedback rules when reacting to the participants' feelings (e.g. *"I understand you're annoyed, and you want to say something about it. Still, could you please let Mother A. finish speaking?"*) - as the participants should with their own children (adjusted for age, of course).

Basic assumptions for the group
- ► Each mother with BPD who is seeking help wants to be a good mother.
- ► She must accomplish more than she believes she can.
- ► She often did not cause her own problems, but she must find a way to overcome them herself - this is unfair.
- ► She is responsible for giving her child care that she often did not receive herself.
- ► She must learn new behavior in many important areas of life.
- ► She needs proper support.
- ► Her child especially needs love, protection and support.
- ► The child's development is in danger if the mother does not learn to correctly meet his needs.
- ► The child directly benefits from his mother's improvement.
- ► Therapists working with a mother with BPD and her children need to work together collaboratively as a team.

The trainers should not shy away from mentioning their own difficulties with child-rearing. It can be a relief to mothers with BPD when they realize that some of their parenting troubles in every-day life are normal.

Division of tasks among the trainers

Just as with regular DBT skills training, it is strongly recommended that two trainers guide the group. One trainer can concentrate on teaching the skills for the given session, while the other can keep an eye on the group dynamics. If one trainer calls out a participant for her problematic behavior (e.g. parenting behavior; disrupting the group), the second trainer should balance this confrontation with empathy.

For the mother-child subject matter, it is also helpful if one trainer can temporarily represent the child's perspective, while the other shows empathy for the mother.

Example

Mother A: My child didn't want to eat, so I forced a spoon into her mouth. What else could I have done, since she has to eat?

Tr 1:   It sounds like you felt helpless in this situation and didn't know what else to do. Are you afraid that your child won't have enough to eat, or is sick? (Attitude: validating, empathetic).

Tr 2:   How would you react if someone tried to push a spoon into your mouth? Would you then want to eat? If you want your child to learn normal eating habits, it's helpful to stay calm in situations like this. Give your child some time. And if she doesn't want to eat sometimes, that's not such a bad thing. (Attitude: confronting, matter-of-fact).

Mothers often exhibit the same behaviors and emotions that they report in their children (e.g.

defiance, impulsive and aggressive behavior, guilt, shame, anxiety). It is helpful to name this observation and use it as a resource. For example: *"When you get angry when something is too hard for you, it reminds me of what you just said about you son. Could you two actually be very similar? Maybe looking at yourself can help you understand your son."*

Promoting openness

Supportive and appreciative communication is important in creating an open and unified atmosphere in the group. The trainers should promote openness by sharing their own difficulties with child-rearing, or by positively reinforcing honest statements from the participants.

For example, a mother says that she has hit her child and dragged him across the road. The trainer says, *"It`s good that you shared this with us. Who else has ever reacted like this in a high-pressure and dangerous situation? Let's think about what we could do differently in stressful situations like that."*

2.3 Intervention strategies in specific or difficult situations

Recommendations

The following points give some recommendations on how to approach difficult situations that frequently occur in the group.

A participant did not complete her homework. The importance of homework has already been mentioned. As a general rule, the participants' motivation to do their homework can never be too high. Throughout the training there are always participants who did not do the homework for various reasons. The first time they fail to do so, the trainers should explore and validate their obstacles. The following points suggest reasons why a participant may not have done her homework, and recommend specific strategies for each case:

▶ The participant forgot to do her homework.
→ Supportive strategy: "How can you make sure that you remember to do it next time?"
▶ The participant did not have enough time to do it; she is under great stress.
→ Look for potential free time in her schedule: "When and where can you take the time to do the homework?"
▶ The participant did not understand the assignment.
→ Explain the assignment again and give a concrete example.
▶ The homework is too hard for the participant.
→ Simplify the exercise and discuss ways to support her.
▶ The participant does not judge the assignment to be effective.
→ Point out that she can only know this if she has tried it. "What indicates that the assignment is not effective? What suggests it may be effective? Have you tried it?"

The trainers should recognize and validate the reasons for the participants' difficulties, but they must also emphasize the importance of the homework in order for the training to be successful. Each participant should develop ideas for overcoming obstacles—first on her own, then with the help of the other participants, and finally with the help of the trainers. The same strategy should be applied with participants who only partially completed their homework, or did not write it down.

It is important not to give a participant who did not do the homework too much attention or allow her to take up too much of the group's time, so as not to reward disregarding the assignment with increased attention. The participants who fully completed their homework in writing should always start. If a participant repeatedly does not do her homework, the trainers should discuss this with her individually.

Refusal to participate in behavioral rehearsals and disruptive behavior in the group. Occasionally, participants will refuse to participate in behavioral rehearsals or role-plays, give devaluating comments, or disrupt the others.

The trainers should point out that it is important that all participants join in the behavioral rehearsals, and encourage them all to try it at least once. Often it is helpful to remind the group that children as well are expected to try new things and participate in group activities, whether in daycare or in primary school, even when they do not always want to. A trainer could say, *"How can we expect our children to do what we can't do ourselves? When we realize how much effort it takes to integrate into a group, and when we try to do it ourselves, it's easier for us to help our children with similar difficulties."*

At the same time, no participant should be forced or morally pressured to participate. If necessary, a participant can sit out and watch the behavioral rehearsal. It should be made clear that the participants can learn much more if they perform the rehearsals themselves. The trainers should discourage the participants from making dismissive remarks and giving skeptical looks. If participants behave negatively toward the others, the trainers should address this and discuss it with them in an individual session.

If a participant repeatedly refuses to take part in the rehearsals or is consistently disruptive, the trainers should discuss this with her individually in order to avoid taking up too much time in the group. Likewise, when a participant repeatedly misses sessions without a valid excuse, the trainers should discuss this and question her group participation with her separately.

Dealing with success or failure in applying skills. The trainers should reinforce and acknowledge all attempts to try something new, regardless of the result. Successful application of skills typically has a self-reinforcing effect, but success is often only visible after some practice.

Praise should always be honest and appropriate. Too much praise for an individual participant can either seem unconvincing or dishearten the others who are trying equally as hard, but are less successful. Instead, the group should explore how each participant succeeded in applying new skills, as well as what was difficult or helpful for each.

Similarly, a more exploratory stance should be taken with regard to failures: What did the participants try? What were the obstacles? How could they do it differently next time? In all cases it is helpful to include the group in this discussion.

Strong emotional impact. Often, the participants respond very emotionally to their failures, e.g. with guilt, sadness or anger. The likelihood of a strong emotional response rises when the participants begin to emotionally understand the consequences of their dysfunctional behavior for their children.

The trainers should acknowledge that it is painful and difficult to grapple with one's own shortcomings. Feelings of pain and guilt can also be understood as expressions of love for the child (*"A mother who doesn't care about her child wouldn't suffer so much if she had made a mistake."*) It is worthwhile for the participants to address these issues, as it is the beginning of a beneficial change: *"Only a mother who really cares about her child would make this sort of effort*

to improve."

Traumatic experiences. It may happen that mothers in the group remember their own earlier traumatic experiences and want to share them with the others. The trainers should react to this with empathy and validation. For a more in-depth discussion, however, the trainers should direct these participants to individual therapy.

Trainers' own values. It may also happen that a trainer is offended or upset when, for example, a mother violates the trainer's values through racist or contemptuous remarks, lack of empathy, or egotistical behavior. In this case, the other, less-affected trainer should work with that mother. This type of situation illustrates the importance of having two people leading the group who can support each other.

It is important to maintain a matter-of-fact, empathetic and appreciative attitude to all topics. Moral indignation is generally not helpful and should be avoided.

Evaluations, criticism and advice in the group. Group members often have different understandings of parenting styles and methods, usually based on personal experience (*"Which is worse, growing up in an institution or an abusive family?"* or *"Which is worse, constantly fighting in front of my child or showing no feelings at all?"*).

The trainers should clarify that the right way to act in a particular situation depends on many factors, and that each mother can only judge her own experience. Additionally, there are often no clear rules of conduct in difficult situations. The trainers should help the participants to replace an "either-or" attitude with a "both-and" attitude (*"Both are unfavorable—to be constantly fighting and showing no feelings at all. The point is to find a healthy compromise"*).

Occasionally, the participants will devalue each other aggressively (*"Well, I would never feed my child that kind of muck to eat."* or more subtly: *"It's important to me that nothing bad happens to my child, so I would never leave him in his room unattended"*). The trainers should point out that this sort of remark is not helpful. It is also beneficial to refer to the group rules in such moments. Criticism should only be constructive, and given with the consent of the participant to whom it is directed.

Dealing with advice is somewhat more difficult. It is good for the women to exchange solutions that they have found successful in their own lives. However, the trainers should always structure this exchange as much as possible, and advice should be limited and only given at the request of the participant to whom it is directed. Otherwise, it is easy for wellmeaning "experts," who have a quick solution to every problem but are perhaps avoiding their own deficits and needs, to establish themselves in the group and dominate the group process.

It is important for the trainers to maintain distance from their own "standards". It might not be the best solution if a three-year-old watches a cartoon while the mother prepares breakfast. But it still is a (temporally) better solution than the child having to endure daily outbursts of anger and loss of control from the mother.

Role-plays. Role-plays are an essential and proven technique in group work. They serve to better assess the actual behavior of the mothers, help to develop alternative behavioral strategies and foster a change of perspective. It is important to accurately divide time during the role-plays to allow all of the mothers a chance to participate. It is helpful to select short and concrete situations and provide a very clear sense of direction in terms of a stage direction. Ideally, each participant should engage in the role-plays. If all the participants cannot have a turn due to

time constraints, it is very important to ensure that those who did not join in actively do so in the next behavioral rehearsal. This is especially important for rehearsals that are recorded on video and watched afterwards. The trainers should always acknowledge when someone has not had a turn or her turn has been deferred for logistical reasons.

Role-plays usually function well and are, as stated, a very important therapeutic tool for the mothers to try new behavior and prepare for behavioral rehearsals with their children. Sometimes it is not easy to get the participants to join in with the role-plays at first—they are often anxious and ashamed to reveal their deficits. Many women in the group might also have a very negative self-image and cannot bear to see themselves on video. To overcome this obstacle, it is helpful to play very short sequences, and deliberately try out wrong or funny variations during the rehearsal.

In any case, the trainers should inform the participants before the training that the role-plays are mandatory.

Convincing mothers to participate in role-plays. The following arguments can be helpful in convincing the participants to take part in role-plays:

► "You are not alone with your difficulties; many have similar problems."
► "The fact that you have these difficulties means that you belong in this group."
► "Even if you can't imagine it now, based on our experience, we're sure that after a while the role-plays will be easier for you, and you'll really benefit from participating."
► "It takes courage to overcome your fears, I believe in you."

Conducting the role-play. When performing the role-plays, the following must be noted:

► Particularly for the first role-play, the time should be adequately divided so that each mother has a turn.
► The role-play instructions should be clear and concrete, and the selected situations should be of medium difficulty for the mothers.
► When the circumstances demand it, a trainer should be available as a role-play partner to make it easier and promote a sense of achievement. When the group is more familiar with the role-plays, the mothers should do the role-plays with each other. This has a positive side effect: the participants can directly experience the effects of parental behavior in identifying with their children.
► After each round, the group should watch the role-play on video and immediately evaluate it. First, the participant who performed the role-play should describe what was successful, then the other group members should give feedback. Keeping a generous mindset is difficult for most of the mothers at the outset—it is easier and more familiar for them to be critical of themselves and others. The trainers also tend to make suggestions for improvement too quickly. It is especially important for the mothers to learn how to positively assess their own behavior—when women with BPD learn to see themselves in a favorable light and focus on their resources, they experience greater relief in a shorter amount of time, and can be friendlier with other people and especially with their own children.

It is difficult for many to accept praise (*"She's only saying that because she has been told to be positive"*). It is sometimes easier for the participants to accept positive feedback if they are also given constructive criticism (*"Now I believe your compliment was honest"*).

Participants usually accept constructive and concrete suggestions and observations gratefully, as they demonstrate the group's genuine interest in the progress of each individual mother.

2.4 Individual sessions

In the following, the procedure for each individual training session is described.

2.4.1 Session 1: Borderline Personality Disorder and motherhood: Risks and opportunities for mother and child

Objectives of the session
► to get to know one another
► to teach the mothers about the risks to the children of mothers with BPD
► to demonstrate the potential to reduce these risks through action
► to introduce the content and structure of the training
► to address questions and reservations

Materials
► Handout 1a: Difficulties and risks
► Handout 1b: Basic premises for working in the group
► Handout 1c: Rules for giving feedback
► Handout 1a Tr: Mindfulness and activation exercises
► Handout 1c Tr: Tension/Stress curve
► Homework sheet 1: Reward card
► egg timer/timer
► flip chart
► folders
► consent forms

Background knowledge for trainers. The beginning of the first session serves as a round of introductions. Next, the trainers should illustrate the content of Handout 1a, "Difficulties and Risks," by using examples elicited from the mothers themselves. On the one hand, it is important to explain the risks that mothers with BPD pose to their children from a scientific perspective, but it is also necessary to discuss the mothers' resources and emphasize that they can have a positive influence on the development of their child.

The interaction model (see H 1a) classifies typical BPD symptoms and comprehensively describes their effect on a child's well-being. The focus therein is the "vicious cycle" of vulnerability and maladaptive parenting strategies.

It should be made clear that mothers with BPD are a heterogeneous group, with each mother having her own individual problems, despite commonalities due to their condition. The diagnosis alone does not explain everything: each mother's individual, concrete behavior is important. Nevertheless, it should be pointed out that there are a number of similarities which enable group training.

Procedure of the session

Greeting. The trainers should introduce themselves and welcome the mothers. If the trainers are mothers themselves, it is a good idea to share the number and age of their own children with the group, and to say that they also encounter challenging situations with their children, where they sometimes don't have a solution straight away. The trainers should give the participants proper recognition for choosing to partake in this program. The participants often have to overcome organizational obstacles (e.g. childcare, time, and money) in order to come, and it is not easy for them to confront the issue. Each mother's decision to come to the first session should be taken as a sign that she cares about her child's well-being.

Participant introductions (15-20 minutes). The participants should take turns introducing themselves, addressing points that the trainers specify beforehand. The trainers should note these on the flip chart: general information (participant's age, the number and age(s) of her children, her relationship status), reason for participating, experience with therapy, and expectations and reservations about the group training. The points can be expanded by 1-2 "fun" points such as favorite food, "If I were an animal" etc.

Organization. The trainers should present the day's agenda on the flip chart. The participants should agree to maintain total confidentiality within the group: everything that is said in the group stays in the group.

Next, each participant should receive her written training materials (folder). The folder should be empty at this time, except for a cover sheet on which the name of the participant is written. The participants will fill the folder with the materials from each session.

Mindfulness exercise. The trainers should then announce that every session will start with a short mindfulness exercise. They should then give a brief instruction for a mindful attitude: "There's no wrong way to do this exercise; you don't even have to like it. It's just about staying with the exercise and always turning back the attention to it."

For the first session, a simple, short mindfulness exercise should be chosen (e.g. a breathing exercise. See H 1b Tr).

Information on the risks to the child's well-being. The trainers should distribute Handout 1a. The trainers should then briefly summarize the results of current research, i.e. which parental behavior is often associated with BPD and what short- and long-term effects such behavior has on children (see section 1.2). This information should be presented as objectively as possible (with a PowerPoint or flip chart presentation).

In some cases, questions or objections may arise in the group. The topic of parentification is a good example: questions about the reversal of roles, such as "Why is it bad when my child comforts me?" and about emotional instability, such as "But is it good to pretend or disguise yourself in front of your child?" should be clarified with a scientific reference: "Of course it might happen that you cry in front of your child sometimes, and that she then comforts you. Still, studies have shown that children can have trouble developing healthily when they regularly have to take on the role of the parent."

The participants may also wish to talk about their own experiences. Some mothers are shocked by the information presented, especially if their children already show some of the described behavioral problems. Here, it is important to emphasize the changeability of dysfunctional behavior, and explain the associated reduction in the risks to the child. It should also be emphasized that mothers with BPD usually want the best care for their children, but often do not know how to provide it. Again, the trainers should point out that the participants

have already taken the first important step toward this end by participating in the group.

A dichotomous pattern of thinking often emerges from the participants' questions and comments (either-or: e.g. to show no feeling at all towards the child or to completely be out of control in front of the child). At this point, the dialectical attitude of "both-and" can be introduced.

Interaction model. The interaction model (see H 1a) illustrates the relationship between parents' deficits and their children's problems. It is important to point out that a biological predisposition and the invalidating experiences in the past are the starting points for escalating conflicts between mother and child. By using a specific example situation, the development of conflicts is explained within the model. For a better understanding, one can use the "Ferrari metaphor."

> **Ferrari metaphor**
>
> You can think of the biological properties of a person with BPD compared to those of a "normal" person as being like the relationship between a Ferrari and a VW Beetle. A mother with BPD is like a Ferrari: fierce; able to accelerate from zero to one hundred; full of energy. But if you can't brake quickly enough you can easily get off track. It is also quite likely that your child is like a little Ferrari, and they you both quickly find yourselves on a crash-course.

The trainers should make sure that the participants have adequately understood the information through the examples provided. If the participants are not yet familiar with the stress curve model (see H 1c Tr), the trainers should explain it at this stage.

After the 20-minute break, the trainers may continue to present information on risks to the child if they have not yet finished covering the topic.

Introducing the training. Using H 1a Tr, a brief overview of the thematic modules, the course content and the structure of the training is given. It is particularly important to stress the importance of homework and independent practice, so that the work done in the group can be transferred to everyday life. At this point, the trainers should also mention the reward cards for completed homework, and introduce and discuss the feedback rules (H 1c).

Basic premises for working in the group. The should trainers distribute the handout of basic premises (H1b), and the participants should take turns reading them aloud. The trainers should explain each of these points: they represent the assumptions of the trainers about the participants' basic willingness to take part in the group program.

The basic premises, especially the sentence "Every mother with BPD who is seeking help wants to be a good mother," illustrate that the trainers assume the participants are able to make important changes in their lives. The trainers thereby support the mothers. At the same time, the basic premises are an appeal to each mother's own responsibility ("She often does not create her own difficulties, but she has to overcome them herself") and her responsibility to her child ("The child's development is in danger if the mother does not learn how to correctly meet her needs").

Homework. For the next session, the participants should thoroughly read Handout 1a, "Difficulties and Risks," answer the questions in the text, and write down their own examples.

Organization. The group should discuss the dates for the next sessions. The trainers should distribute the reward cards (HS 1).

Conclusion. In addition to giving a small amount of feedback on the first session, at this point, the participants should express their willingness to participate in the training. The trainers should collect the consent forms that the participants received in the preliminary screening.

2.4.2 Session 2: Mindfulness

Objectives of the session
► to emphasize the importance of mindfulness for the mothers and in dealing with children
► to explain that mindfulness is helpful in:
  – learning to see children in a more differentiated and realistic way
  – evaluating oneself as a mother in a more realistic way
  – distancing oneself from one's own patterns of perception and reaction and therefore improving behavioral and emotional control

Materials
► Handout 2: Mindfulness
► Homework sheet 2a: Mindfulness in perceiving
► Homework sheet 2b: Mindfulness in doing
► Homework sheet 2c: Mindfulness log
► raisins
► stickers for reward cards
► flip chart

Background for trainers

When teaching mindfulness, it is essential to be able to draw on one's own experiences. The trainers should have already performed the mindfulness exercises themselves and practiced guiding them.

A basic obstacle in the practice of mindfulness is that it is effective in the long term, but is often perceived as aversive and ineffective in the short term. Therefore, the regular practice of mindfulness requires conviction, determination and discipline. The trainers should address potential obstacles and seek clear agreement about the exercises. It is important that the trainers are familiar with this subject matter from their own practice.

The difference between "mindfulness" and "relaxation" is addressed: mindfulness is not about generating a pleasant feeling, but about being attentive, curious, and accepting towards all experiences (positive or negative). Essentially, mindfulness is the knowledge that valuations and a strong desire to want or to get rid of certain feelings, thoughts, attitudes or life-situations only worsens one's current suffering or problems in the long run.

Using the raisin exercise, the participants can start to form a new relationship with their experiences, which stands in contrast to how they normally think and behave when on "auto-pilot."

The mindfulness exercises in the homework are structured such that they can be easily integrated into everyday life with a child. They are aimed on the one hand at internal mindfulness (non-judgmental, concentrated perception and description), and on the other hand at mindfulness when interacting with a child—for instance when playing or singing.

Procedure of the session
Greeting. The trainers should present the day's agenda.
Aversive tension rating. Each participant should rate her tension on a scale from 0-100.
Mindfulness exercise. The group should perform a mindfulness exercise (see H 1b Tr.). As

mindfulness is introduced in detail in the second part of the session, a short and easy exercise is recommendable.

Feedback and questions from the participants. Sometimes, the participants may have questions or hesitations that have arisen since the first meeting. The trainers should ask the group about any concerns so that they can be clarified.

Discussion of the homework. Each participant should present her own examples from Handout 1a (H 1a). The participants should be encouraged to share their individual difficulties and challenges. The trainers should distribute the stickers for completed homework.

There is a 20-minute break.

Introduction to mindfulness. The trainers should distribute Handout H 2, "Mindfulness". The trainers should then use the stress curve (see H 1c Tr) to explain how one's perception is altered by one's stress level (e.g. "When I'm very stressed, I get annoyed about small things that don't usually bother me"). The participants should be asked to offer their own examples.

The ABC Model (from Ellis, 1991) should then be introduced using an easy example (e.g. see below). The meaning of A – Antecedents, B – Belief, C – Consequences should be explained. Afterwards, the model should be applied to the participants' examples.

> **Example for the ABC model**
>
> "When I talk and my conversation partner looks away (A = Antecedent), I think, "She's not interested in what I'm saying; I'm boring." (B = Belief). Then I feel sick and sad, and I retreat (C = Consequence).
>
> Alternative assessment: "When I talk and my conversation partner looks away (A = Antecedent), I think, "Maybe she's just distracted, or she's thinking about what I said" (B = Belief). I pause for a moment, and then I ask her about it (C = Consequence).

When assessing the examples, it should be pointed out that while thought processes are often automatic rather than conscious, they nonetheless have a great influence on our perception and well-being. Mindfulness can help to "drive a wedge" between the antecedent and the reaction (consequence), giving us more conscious control over our beliefs, and therefore over our feelings and behavior.

Mindfulness is the underlying basis for all skills practiced in this training.

The raisin exercise. Each participant should be given a raisin. One of the trainers should lead this mindfulness exercise, and the other should take part in it.

"Now you all have this small object in your hand. Imagine that you're seeing it for the first time in your life, as if you come from a foreign land where these things don't exist. Now, study the object as if you have to describe it in full detail to your fellow citizens later.

Examine it carefully first…hold it against the light and feel it with your fingers, feel its surface and its texture…and whenever your thoughts wander, take note of that as well. It is completely normal for our thoughts to wander. When you notice this, simply bring your attention back to the object…You can also bring the object to your ear, and maybe you'll hear something…Now bring the object to your nose and sniff it…Notice if you are judging - appealing or unappealing? Acknowledge these thoughts, let them be, and then bring your awareness back to the object. Explore the quality of the smell.

Now, bring the object to your mouth…Feel it with your lips, then put it in your mouth, first without biting…Take note of what is happening in your mouth…Then begin, very slowly, to bite and chew. First, resist the impulse to swallow…Take note of the taste…what changes in your mouth? How does the object's texture change?…Now look at what happens when you swallow…What does your tongue do? Take a moment to feel the effects…Now, very slowly, bring your attention back to the group."

Analysis. The participants should be asked to describe their experiences with the help of open-ended questions (e.g. "What was your experience? What did you notice while doing the exercise?"). The trainers should take a non-judgmental, exploratory stance and make sure that the participants do not talk judgmentally amongst themselves about their experiences. The group can then discuss the difference between "normal" and "mindful" raisin-eating experiences together. The trainers should also share their own experiences with the exercise.

Frequently, participants initially focus on negative experiences in their feedback. It is part of the exercise to take note of these aversions. They should also be written on the flip chart and should always be validated. Examples of aversive experiences are judgmental thoughts (e.g. "this is silly"), negative feelings (disgust, reluctance), unpleasant physical sensations (restlessness, tension), as well as impulses to stop the exercise and turn to other things.

Dealing with aversive experiences. The following dialogues give three examples of dealing with aversive feelings.

Example 1.

Mother A. "What did I just experience? Nothing special. "

Trainer. "So you think what you just did wasn't special. What exactly did you taste?"

Mother A. "Well, it tasted like a raisin. "

Trainer. "Imagine I don't know what a raisin tastes like, or even what it is. How could you describe the taste to me? "

Example 2

Mother B. "I couldn't concentrate at all. I only thought, is this almost over? Why should I be here for minutes on end, looking at a raisin?"

Trainer. "Did you notice these thoughts during the exercise? What happened then?"

Mother B. "I got really nervous, and most of all I wanted to stand up."

Trainer. "Can you describe those physical sensations more precisely?"

Example 3

Mother C. "I didn't like the taste of the raisin and I quickly swallowed it."

Trainer. "Could you describe the precise moment that you swallowed the raisin? What was going through your mind shortly before? Did you have a physical reaction to it?"

Mother C. "Yes—I thought I would be sick if I kept chewing. And then I thought, what's the point of all this anyway!"

Trainer. "Well observed! Could it be that you felt disgusted and a bit annoyed about the exercise?"

Mother C. "Yes, maybe!"

Trainer. "Then it's clear that when something doesn't appeal to you, you don't want to

explore it! Could you have had another choice in that moment besides quickly swallowing the raisin?"

Transferring mindfulness to everyday life. Afterwards, the participants should discuss the generalization of the exercise. They should consider together how the raisin exercise relates to their child and their parenting. A mindful attitude facilitates the upbringing of a child, e.g. assessing and meeting his needs appropriately, overcoming preconceived notions, and better perceiving what is actually happening. It should become clear that mindfulness is also an exercise in examining and accepting unpleasant experiences. This is a useful point, because everyday life consists of both pleasant and unpleasant experiences, which can only be influenced if they are perceived. Often, bad experiences, expectations and prejudices lead to inaction. Mindfulness can sharpen the eye for new experiences and possibilities. In the long-run, mindfulness leads to more control and better quality of life.

Finally, the trainers should summarize the characteristics of mindfulness:

Characteristics of mindfulness
► **Concentration** - paying deliberate attention, taking note of distractions, and always bringing one's attention back to the focus.
► **Acceptance** - non-judgmental. Above all, this means accepting one's thoughts and feelings ("I'm annoyed at the moment").
► **Effectiveness** - pursuing one's goal, and perceiving and overcoming obstacles ("I'm going to concentrate on changing my child's diaper, and I will do what is necessary for this and neglect what makes this task so hard").
► **Beginner's mind** - always looking at things afresh, as if it were the first time.

Homework. The participants should read Handout 2, "Mindfulness".
The Homework sheets 2a ("Mindfulness in perceiving"), 2b ("Mindfulness in doing"), and 2c ("Mindfulness log") should be discussed. The participants should choose one or two mindfulness exercises from Homework sheet 2a, which they will practice daily. The trainers should make concrete arrangements (time, place, situation) as much as possible, and discuss how to handle possible obstacles with each participant. Additionally, the participants should choose five activities from the Homework sheet 2b to do with their child. They should record these exercises in their mindfulness logs after they have completed them (HS 2c).

Every participant should be asked to state an individual take-home message.

Exemplary take-home message
In everyday life, it is helpful to be mindful in dealing with oneself and one's child. Both pleasant and unpleasant thoughts and feelings should first simply be perceived. Mindfulness is not about relaxing or only thinking positively, but about observing things as they appear to you.

2.4.3 Session 3: The basic needs of children

Objectives of the session
▶ to provide information on and encourage understanding of the basic needs of children, and establish agreed-upon standards in dealing with children
▶ to help the participants to complete their first self-assessment of their strengths and deficits in childcare

Materials
▶ Handout 3: The basic needs of children
▶ Homework sheet 3: The basic needs of children
▶ flip chart
▶ stickers

Background for trainers
Children have basic needs such as sleep, food, closeness, and security. Handout 3, "The Basic Needs of Children," gives an overview of physical needs (such as hygiene, health, and nutrition) as well as emotional needs. How safe and confident a child feels, how she deals with her feelings, and how she develops her relationships all crucially depend on the quality of emotional care she receives. A child needs age-appropriate and affectionate physical contact regularly—not only when the parent is in the mood for it. The mothers may know how to attend to their children's basic needs (sleep, nutrition), but not how to support them emotionally—precisely because they rarely experienced such support themselves. They often cannot distinguish between a child's essential needs, such as regular meals, and her desires, such as for sweets (see H 3).

Throughout the session, questions frequently arise on the topics: "What is an appropriate diet?"; "Should a child be allowed to sleep in her parents' bed?"; "Is yelling a form of violence?", "Should a child be allowed to watch television, and if so, at what age and how much?" The participants should be encouraged to share their views in the group and, above all, to share their difficulties (but the trainers should cap these discussions if they go too far). The group can help individual participants develop strategies to better deal with their children's needs. For the trainers it is important to convey the message that there is not only one "right" way to deal with basic needs but a large variety, depending on the individual relationship between mother and child.

The participants' needs. The approach described in this chapter has proven helpful in meeting the following participant needs and desires:
▶ need for concrete advice
▶ to experience support, group solidarity and cohesion
▶ the wish for active participation
▶ imparting a feeling of competence

H 3 can be used to supplement the list of children's needs that the trainers elicit from the participants.

Basic needs include nutrition, a place to sleep, clothing, physical care, protection, supervision, health and medical care, emotional attentiveness, a daily routine, and freedom from violence. Parents should learn to assess the needs and demands of their children, as well

to assess their own deficits and competences in various challenging situations. While many participants have good resources for basic material provision for their children, they often have trouble, as one would expect, in situations

► that are stressful
► in which empathy and flexibility are required
► in which the needs of children are in strong contrast to the mothers' own needs or capabilities
► in which they misinterpret their children's comments or behavior.

Especially in the case of competing and seemingly contradictory needs (for example, protection from danger vs. autonomy: a mother does not let her one-year-old child walk by herself out of fear that the child will get hurt), it is often hard for a mother with BPD to find some middle ground. Mothers often try to justify or trivialize their previous behavioral habits (e.g. *"I am a single mother—what else could I have done?"*), or discuss such situations very emotionally.

> **!** It is particularly important for the trainers to have a validating attitude in this session. It is always helpful to suggest considering the child's perspective, and to supplement this suggestion with experiential and research findings (*"Studies have shown that children must learn to assess their own abilities. Of course a mother has to protect her child from dangerous things, but it's still important that the child has a sense of autonomy."*). Dialectical views are also helpful in discussing basic needs: "It's important to find a compromise. You can reassure your child that you're there and support her while she's learning to walk, and at the same time give her some space. Giving your child some freedom doesn't mean that you need to leave her unattended." The trainers should take a clear stance on the topic of violence and parenting, as far as basic norms are concerned. They should always encourage openness: "You can only change something when you honestly point out what's wrong."

Procedure of the session

Greeting. The trainers should introduce the day's agenda.

Aversive tension rating. Each participant should rate her tension on a scale from 0-100.

Mindfulness exercise. The group should perform a mindfulness exercise (see H 1b Tr.).

Discussion of the homework. The participants should take turns presenting their findings from the homework on the subject of mindfulness (HS 2c). The trainers should particularly emphasize that there is no "wrong" or "right" way to do a mindfulness exercise—it is only necessary to take a deliberate, non-judgmental approach. The group should explore this approach through discussing the participants' obstacles to performing the exercise (e.g. aversion, discomfort, intrusive thoughts, external circumstances, expectations, etc.) as well as their new experiences with mindfulness. The trainers should validate every deliberate attempt to perform the exercise, regardless of the outcome.

Trainer.   "How did the exercise go for you?"
Mother A.   "Very badly."
Trainer.   "What did you notice?"
Mother A.   "I got really angry."

Trainer.	"What were you so angry at?"
Mother A.	"I don't know—myself, the exercise, everything."
Trainer.	"What did you do then?"
Mother A.	"I stopped doing the exercise."
Trainer.	"Could you tell us more precisely how your anger developed, and what happened right before you quit doing the exercise?"
Mother A.	"First, I tried to concentrate, but it didn't work. That annoyed me. By the end I thought it was a stupid exercise. I'm sorry, but you asked—it was completely pointless."
Trainer.	"You might be surprised, but I'm happy with you. You did the exercise and told us honestly what happened. It wasn't so pleasant; it was hard for you—it's completely normal for someone to want to quit doing something unpleasant. Still, you tried it, and took note of the point at which you stopped. Now, could you think of something you might have done instead in that moment? "

The trainers should develop individual ways for each participant to continue practicing. They should continually emphasize that every attempt to practice is already an important step. The trainers should distribute the stickers for completed homework.

There is a 20-minute break.

Introduction to the topic of the basic needs of children. The trainers should begin with an imagination exercise. One trainer should lead the exercise, and the other should participate: "Imagine your child sleeping. What position is she in? Is she moving or staying still? Does she have a stuffed animal? Consider the surroundings, the space around the bed…put yourself in your child's position…imagine that you're lying there and you slowly wake up…what do you notice? What do you feel? What would you like to do most?"

Analysis. Based on the participants' imaginings, the trainers should help the mothers to analyze their ways of dealing with their children's needs. They do this in the following steps:

(1) Empathize with the child's needs: what does she require? What are her basic needs (e.g. "She needs attention, closeness, food.")? The trainers should write down the points on the flip chart.

(2) What are the differences between needs (required) and desires (optional)? (e.g.: "The need for food is essential and has to be addressed; the desire for sweets is optional and can be fulfilled depending on the situation or the rules regarding sweets.")

(3) Which needs are easy for the mother to meet and which ones make it difficult? (e.g. "It is easy to provide food and clothing – but it is rather difficult to provide physical closeness or emotional care")

(4) Empathize with the child's reaction to one's own behavior. How does the child feel when the need is addressed/not addressed? How will she react? (e.g. "She smiles and seems satisfied when she gets attention. But she gets uneasy when she is ignored.")

(5) Conclusion: is there anything to change?

Additional basic needs. The trainers should distribute the Handout H3 "The basic needs of children." The group should discuss additional needs that have not yet been mentioned.

Homework. The participants should read H3. Homework sheet HS 3 "The basic needs of children" should be discussed. In the following week, the participants should carefully take note of which of their children's needs are easy to address and which are difficult for them to fulfill, and how they can better do so. This task is noted on HS 3. The trainers should emphasize that this activity is not about doing everything right, but rather recognizing what the mother can and wishes to change.

Every participant should state an individual take-home message.

> **Possible take-home message**
> It is not possible to do everything right. Still, a mother should know and meet her child's basic needs. If this is difficult to do with some of the basic needs, the mother should seek help.

2.4.4 Session 4: Stress

Objective of the session
► to teach the participants about the development of stress, emphasizing the relationship between stress, high tension, and impulsive behavior, and clarifying the risks for a child's well-being
► for the participants to develop individual stress profiles, and individually assess risk situations for themselves and their children
► for the participants to empathize with their children when the mothers themselves feel stressed

Materials
► Handout 4: Development and experience of stress.
► Homework sheet 4a: Stress-related situations, thoughts, and reactions
► Homework sheet 4b: Individual examples of stress
► bowl, waters, bricks (test them in the water before the session—bricks that float should not be used)
► stickers
► flip chart

Background for trainers
High aversive inner tension, strong reactivity to stressors and high sensitivity to emotional stimuli are core symptoms in individuals with BPD (Lieb et al., 2004).

High inner tension is a risk factor for dysfunctional behavior. On the one hand, individuals in such a state often lose their sense of empathy, and can no longer access their parenting resources. On the other hand, they also frequently use dysfunctional strategies such as aggressive or invalidating behavior, withdrawal, or harming themselves or others to regulate tension. They can experience dissociative symptoms and lose control over their own behavior. Since these types of behavior can be frightening, hurtful, and even dangerous to a child, it is important that the participants know their own stress profiles and learn to evaluate themselves in order to prevent risks to their children.

Procedure of the session
Greeting. The trainers should introduce the day's agenda.
Aversive tension rating. Each participant should rate her tension on a scale from 0-100.
Mindfulness exercise. The group should perform a mindfulness exercise (see H 1b Tr.).
Discussion of the homework. The participants should take turns presenting their findings from the homework (HS 3 "The basic needs of children"). First, the trainers should commend each participant for those aspects that are already working well. Next, each participant should think of concrete and realistic goals for improvement in the areas in which they are struggling (if necessary, with the help of the group) and note them on the Homework sheet (HS 3).
The group can support an individual participant as she develops an alternative strategy for facing her own problems, but only if the individual participant wishes. Most of the time, it is good for the other participants to give advice, but it is important not to comment on or discuss these suggestions at first—they should merely be compiled as part of a problem-solving

process. The individual participant should then decide which strategy she would like to try.

The trainers should distribute the stickers for completed homework.

There is a 20-minute break.

Introduction: "clapping and snapping". Each participant should be assigned a number. Everyone should then clap (CL) and snap (S) together in a repetitive rhythm: CL once on the right thigh and once on the left, then S once with the right hand and once with the left. One trainer should begin by saying her number while snapping with her right hand, and then saying the number of a participant when snapping with her left. The participant she calls on must continue the game in the same way. The participants must all clap and snap in rhythm but pay attention to the numbers being called, which is hard to keep track of and causes many to confuse claps and snaps, legs and hands. This activity is fun for some, but is also stressful for many. Thus, the game is a good introduction to the session's topic. The trainers can thus address physiological arousal, anger and restlessness when explaining the Vulnerability Stress Model (see below).

Introduction to the topic of stress. The trainers should introduce the topic of stress to the group by first raising the question: "What are stressful situations for you?" They should write these situations on the flip chart.

They should then explain the Vulnerability Stress Model using a bowl of water. The bowl of water is placed in the middle of the group. The participants are told to place differently sized bricks (or other objects) in the bowl. The bricks should represent concrete, stress-inducing events. The volume of water at the beginning represents vulnerability, the water line represents stress level, and the spillover represents loss of control. The size of the brick depends on how stressful the participant rates the event it symbolizes, meaning differently-sized bricks could correspond to the same event.

In order to illustrate the subjective experience of stress, the trainers can refer to the clapping and snapping activity, which may have triggered stress for some participants but not for others.

From the participants' examples, the trainers should substantiate the stress model so the participants can understand the difference between stress triggers, stress-exacerbating conditions and attitudes, and stress reactions. The trainers can also refer to the ABC Model (session 2), as well as the Interaction Model (session 1), especially emphasizing the higher vulnerability for stress in individuals with BPD (stress curve).

Homework. The participants should read Handout 4, "Development and experience of stress." Homework sheets 4a, "Stress-related situations, thoughts, and reactions" and 4b, "Individual examples of stress" should be filled out. Each participant should think of an example situation from her own life that she will observe in the following week. The participants should note these observations on Homework sheet 4b, "Individual examples of stress."

Every participant should state an individual take-home message.

Exemplary take-home message

Stress is entirely normal—every mother experiences it when interacting with her child. It is important to recognize which situations put a mother under particular stress, and which of her own attitudes intensify that stress. This way, the mother can develop individual strategies for stress reduction.

2.4.5 Session 5: Stress management

Objectives of the session
▶ for the participants to learn strategies for stress management
▶ for the participants to work on individual stress tolerance skills (crisis kit)
▶ to impart general stress tolerance skills for protecting the child from the mother's impulsive actions

Materials
▶ Handout 5: Stress management
▶ Homework sheet 5a: Stress management
▶ Homework sheet 5b: Stress management: Acquiring skills
▶ Homework sheet 5c: My crisis kit
▶ video camera and viewing equipment
▶ stickers
▶ flip chart

Background for trainers
Dysfunctional coping strategies in stressful situations often lead to short-term relief, but aggravate the situation in the long term (e.g. the mother beats and screams at her child → the child cries → the mother feels momentary relief → the mother feels guilty → the child feels angry and afraid). In this session, the group should develop skills that help the mothers to overcome stress without making the situation worse. It is not a matter of resolving conflicts constructively, but rather of diffusing stressful situations so that the mother and child emerge undamaged. The group will run through stressful situations in role-plays, during which it is important to remain calm and avoid negative consequences.

Procedure of the session
Greeting. The trainers should present the day's agenda.
Aversive tension rating. Each participant should rate her tension on a scale from 0-100.
Mindfulness exercise. The group should perform a mindfulness exercise (see H 1b Tr.).
Discussion of the homework. The participants should take turns presenting their findings from the homework (HS 4b, "Individual Examples of Stress"). In some cases, the participants may have trouble distinguishing between stress triggers and stressful thoughts (e.g. "I think about the reasons why my child cries, and that completely stresses me out."). During the discussion, the trainers can use the stress model (see H 4) to differentiate between the concrete trigger (the crying child) and the thoughts ("I do everything wrong").

The trainers should distribute the stickers for completed homework.

There is a 20-minute break.

Introduction to the topic of stress management through role-plays. Each participant should be asked to think of a situation in which she feels stressed. This can be a situation from

Homework sheet 4a, "Stress-related situations, thoughts, and reactions," or an individually chosen stressful situation with the child. Each participant should play herself, and another participant should play the role of her child. The mother that plays herself should give specific instructions to the one that plays the role of her child so the role-play can be as realistic as possible.

The trainers should record the role-play on video so the group can view it afterwards. After viewing the videos, the participant who played herself should give feedback about how she felt in the situation and what observations she made while watching herself on video, taking into account the questions: What did I do well? How can I improve? How realistic is this situation? How high was my stress level? Is my behavior understandable? Next, the participant who played the role of the child should give her own feedback about how she felt. Finally, the participants who observed the role-play and the trainers should give the mother suggestions for improvement. The trainers should ensure that the group adheres to the feedback rules (H 1c).

The group should carry out this procedure with each participant and her chosen situation.

Analysis of the role-play. The trainers should distribute Homework sheet 5c, "My emergency tool kit." Starting with the individual examples that the participants selected for the role-play, the trainers should collect individual signs of stress and different stress management skills from the group and write them on the flip chart. The participants should fill out Homework sheet 5c, grouping the stress management skills under the different headings on the sheet.

Homework. Handout 5, "Stress management," Homework sheet 5a, "Stress management", and Homework sheet 5b, "Stress management: Acquiring skills" are distributed. The participants should read H5 and HS 5b and fill out Homework sheet 5a, "Stress management". The participants should also note any helpful skills that they discover throughout the week on Homework sheet 5c, "My emergency tool kit".

Every participant should state an individual take-home message.

> **Exemplary take-home message**
> Some stressful situations can be avoided through good planning. However, if stressful situations do arise, the focus is on harm reduction. The crisis kit is designed to help the mothers to better control their experienced stress.

2.4.6 Session 6: Structure and flexibility

Objectives of the session
► to provide guidelines for rules and a daily structure
► to establish fixed and flexible rules through the examples of eating, going to sleep, and social behavior: Which rules are fixed? Which can be negotiated flexibly?

Materials
► Handout 6: Structure and rules
► Homework sheet 6a: A typical day from the mother's perspective
► Homework sheet 6b: A typical day from the child's perspective
► Homework sheet 6c: Daily structure - evaluation
► chopsticks
► stickers

Background for trainers
Mothers with BPD are frequently inconsistent in structuring their daily routine—rules and rituals change depending on the mother's or the child's mood. This tendency can lead to unreasonable rigidity and inconsistency in their parenting behavior, as well as to neglect. As a result, the child frequently feels confused and insecure, which promotes problematic interactions between the mother and child (e.g. while eating or going to sleep), thus intensifying the mother's and child's frustration, stress and dysfunctional behavior.

Procedure of the session
Greeting. The trainers should present the day's agenda.
Aversive tension rating. Each participant should rate her tension on a scale from 0-100.
Mindfulness exercise. The group should perform a mindfulness exercise (see H 1b Tr.).
Discussion of the homework. The participants should take turns presenting their findings from the homework (HS 5a "Stress management"). It is important to figure out which skills especially helped the participants. The trainers should encourage the participants to continue to acquire and develop their own skills, and share these skills with the others. If the participants introduce new skills, the trainers should include these in the collection.

The trainers should distribute the stickers for completed homework.

There is a 20-minute break.

Exercise: "leading and following" After the break, the group should begin the "Leading and following" exercise. The participants should break up into pairs, and each mother should get a chopstick. With the help of these sticks, the pairs should lead each other around the room. They should establish the roles of leader and follower, and then switch them without speaking. It is important to point out that the participants should not talk to each other during the exercise. The goal of the exercise is to give the participants the sense that guiding someone else requires a combination of leadership and flexibility. When the activity is finished, the participants should discuss how they felt during the exercise. This discussion serves as a transition to the theme of

structure and flexibility.

Introduction to structure and flexibility. The trainers should distribute Homework sheet 6a, "A typical day from the mother's perspective", and each participant should fill it out. The group should then analyze everyone's entries. Each participant should specify the areas in which she has very clear rules for her child (e.g. mealtimes), and the areas in which she is very flexible (e.g. bedtime). They should discuss what works well for them and where they see a need to change. The trainers should encourage the mothers to suggest strategies for the others to try, and the mothers should write down the suggestions that they wish to try themselves.

Homework. The participants should read Handout 6, "Structure and rules" The group should discuss Homework sheet 6b, "A typical day from the child's perspective," and Homework sheet 6c, "Daily structure - evaluation." When discussing Homework sheet 6b, the trainers should point out that rules for children need to be understandable and can be helpful.

Every participant should state an individual take-home message.

Exemplary take-home message
There is no yardstick for "right" and "wrong" rules. Rules should be comprehensible so children can follow and orient themselves to them. If a rule is sometimes handled flexibly, the reasons should be explained to the child.

2.4.7 Session 7: Dealing with conflicts

Objectives of the session
▶ to promote non-violent ways of dealing with conflicts
▶ for the participants to empathize with the child in a conflict situation
▶ for the participants to stay safe and clear-headed in difficult situations
▶ for the participants to develop appropriate strategies and reactions in difficult situations

Materials
▶ Handout 7: Conflicts
▶ Homework sheet 7a: Conflicts with your child
▶ Homework sheet 7b: Your own conflicts
▶ video camera and viewing equipment
▶ stickers
▶ flip chart

Background for trainers
Conflicts between parents and children are a part of everyday life. They arise because mothers and children often have different goals. The ability to handle conflicts refers to the capacity to deal with conflicts in a socially acceptable manner, both in terms of one's own interests, and the interests of the other party. It is an essential skill in building and maintaining relationships, but it is a challenge for many people. We learn the foundations of the ability to handle conflicts early on. Therefore, the model provided by our parents, one's own biological make-up (temperament) and one's own experiences with conflicts in the family play a role. The following factors aggravate healthy and appropriate conflict management between mothers and children:

Dysfunctional basic assumptions. A widespread assumption is, for example, that "children must always obey," or the opposite: that "children can always make their own decisions." Dysfunctional basic assumptions and a lack of information about a child's behavior frequently lead to unrealistic expectations, disappointment and frustration.

Misinterpreting the child. Things a child says or does often annoy the mother for understandable reasons (e.g. the child dawdles when the mother is in a hurry). The mother thinks: "He's only doing this to provoke me." In this case, however, the mother is confusing the impact and the intention of the child's action. She assumes that her child is aware of and intends the effects of his actions, or at least accepts them ("he doesn't care about how I feel with this.") This intensifies the mother's anger, and leads to less effective reactions.

Lack of ability to mentalize. Mothers with BPD frequently lack the ability to take on their child's perspective. They do not realize that the child has her own goals and ideas, and they lack empathy for their child's situation.

Lack of adequate parenting strategies. Many mothers can correctly interpret and understand their child's behavior and might even be aware of what is not helpful or even harmful (e.g. shouting at or hitting the child), but they do not know alternative behavior strategies. Often, the mothers have had no constructive model in their lives for dealing with conflicts. In some cases, these mothers had been punished for functional behavior in their own families (e.g. appropriate attempts to get some distance or expressing their needs), while dysfunctional behavior (e.g. impulsive-aggressive behavior, self-harm) was reinforced through attention,

care, and short-term emotional relief.

Children who are confronted with such dysfunctional attitudes and behaviors then have similar experiences as their mothers: their mothers ignore, misinterpret, or blame them for their appropriate behavior, and reward them for dysfunctional behavior ("When mom doesn't listen to me, I whine until she flips out, and then she says she's sorry and takes me into her arms."). It is therefore important to teach mothers with BPD about children's forms of self-expression, and provide them with appropriate strategies for adequately and effectively addressing conflicts.

Procedure of the session

Greeting. The trainers should present the day's agenda.

Aversive tension rating. Each participant should rate her tension on a scale from 0-100.

Mindfulness exercise. The group should perform a mindfulness exercise (see H 1b Tr.).

Discussion of the homework. The participants should take turns presenting their findings from the homework (HS 6b, "A typical day from the child's perspective," and HS 6c, "Daily structure - evaluation"). It is especially important to encourage the mothers' change of perspective when discussing Homework sheet 6b (e.g. "You just said that you can't imagine what it's like for your child when you take her shopping. Imagine now that you're a baby in a stroller, and your mother is pushing you around the supermarket. What do you see? How do you feel?"). When discussing Homework sheet 6c, the trainers should pay attention to whether the participants are able to differentiate between factors that they can and cannot influence. If individual participants have particular difficulties in implementing regular daily routines, it may be useful to refer to the basic needs of children (H 3).

The trainers should distribute the stickers for completed homework.

There is a 20-minute break.

Preparation for conflict role-plays. The trainers should distribute Homework sheet 7a, "Conflicts with your child," and each participant should fill it out. The trainers should briefly explain the goal of this activity: for the participants to record what they would do in a given situation, not to anticipate what the "correct" reaction would be. Next, each participant should select a role-play situation of medium difficulty.

Role-play. Two participants should enact a short role-play, one participant playing herself, and the other playing the participant's child. The mother that plays herself should give specific instructions to the one that plays the role of her child so the role-play can be as realistic as possible. The role-play should be recorded on video, and when it is completed the group should watch the recording. After watching the video, the participant who played herself should first evaluate her own performance, considering the questions: What did I do well? How could I improve? How realistic was this situation? How high was my stress level? Is my behavior understandable? Next, the participant who played the role of the child should give her own feedback about how she felt. Finally, the participants who observed the role-play and the trainers should give the mother suggestions for improvement. The trainers should ensure that the group adheres to the feedback rules (H 1c).

The group should carry out this procedure with each participant and her chosen situation.

Analysis of the role-plays. Starting from the mothers' own examples, the trainers should collect suggestions for alternative strategies to deal with conflicts and record these on the flip chart.

Homework. Participants should read Handout 7, "Conflicts". The group should discuss Homework sheet 7b "Your own conflicts". The participants should write down a typical conflict situation with their child that they want to observe during the following week.

Every participant should state an individual take-home message.

> **Exemplary take-home message**
> Conflicts are part of everyday life and cannot be completely avoided. However, one can learn to respond to a child's behavior so that conflicts do not always escalate. To this end, it is important to first observe oneself in conflict situations in order to develop and try out new behavior strategies.

2.4.8 Session 8: Dealing with emotions

Objectives of the session
- ▶ for the participants to observe and identify their own and their children's emotions
- ▶ to recognize the relationship between emotions and behavior
- ▶ to adopt a validating attitude towards the participants' and their children's emotions; to learn there are no "right" or "wrong" emotions, but there is appropriate and inappropriate behavior

Materials
- ▶ Handout 8: Dealing with emotions
- ▶ Homework sheet 8a: Dealing with your own emotions
- ▶ Homework sheet 8b: Dealing with children's emotions
- ▶ stickers
- ▶ flip chart

Background for trainers
Difficulties in emotion regulation are central in BPD. These encompass deficits in perceiving and differentiating between emotions, a lack of emotional control, and a tendency toward emotional expressions that are too strong, too weak, or inappropriate. Mothers with BPD often invalidate and misinterpret their children's emotions; at the same time, conflicts with their children often trigger "old feelings" and memories of the mother's own painful past experiences. When working with the mothers, it is common to focus on anger, guilt, and helplessness in their interactions with their children. As long as these emotions determine the mothers' behavior, we can speak of a vicious cycle of anger-blame-disappointment-helplessness in parenting.

In this session, the mothers will be taught to deal with their children's and their own emotions so they can prevent conflict escalation. The lessons will try to counteract the risk of permanent invalidation and potential risks for the child's welfare. However, the group session only provides an impetus for the mothers to appropriately handle their own and their children's emotions. In-depth treatment in individual therapy or regular DBT skills training is necessary in addition to the group work.

Procedure of the session
Greeting. The trainers should present the day's agenda.
Aversive tension rating. Each participant should rate her tension on a scale from 0-100.
Mindfulness exercise. The group should perform a mindfulness exercise (see H 1b Tr.).
Discussion of the homework. The participants should take turns presenting their findings from the homework (HS 7b, "Your own conflicts"). It is important to emphasize again which behaviors are functional and which are dysfunctional in conflict situations. Especially when individual participants are unable or unwilling to refrain from dysfunctional reactions (crying, hitting), it is necessary to explain once more the long-term consequences of these behaviors on the child's development (H 1a: "Difficulties and risks").

The trainers should distribute the stickers for completed homework.

There is a 20-minute break.

Short imagination exercise. One of the trainers should give the instructions for the exercise: "Imagine the following situation: you are on the playground with your child. After a while, you realize that you have to leave so you can go shopping for dinner. You ask your child to come with you. Your child starts flailing around, cries, and yells 'you stupid mom!'. How do you feel? What impulses do you have?" The participants should take turns sharing their thoughts as to how they would feel and what they would want to do in this situation.

This exercise serves to activate the participants' emotions and to spur analysis of their own reactions to emotions. Usually, it becomes clear that every woman reacts emotionally in a different way, and develops different behavioral impulses.

Introduction to the topic of emotions. The trainers should distribute Handout 8, "Dealing with emotions," Homework sheet 8a, "Dealing with your own emotions," and Homework sheet 8b, "Dealing with children's emotions". Using Handout 8, the trainers should introduce the topic of emotions. It is important to avoid a lengthy discussion—the introduction is simply meant to show that there are many different types of emotions and each person reacts differently.

First steps into the topic of dealing with emotions. Next, the participants should fill out the first part of Homework sheet 8a, "Dealing with your own emotions" (own emotion). The trainers should then write these responses on the flip chart. The participants frequently name emotions such as helplessness, despair, and shame. This activity is not meant to help the group distinguish between primary and secondary emotions, but rather to record the emotions and states which the participants think are important.

Afterwards, behavioral impulses in the situation should be discussed and matched to the corresponding emotions. Participants here realize that the same emotion can lead to different behavioral impulses – as well as one behavioral impulse can arise from different emotions.

Example of a completed table from Homework sheet 8a (first section)

Own emotion	Behavioral impulse
fear	ask the child to stop
anger	hit the child back, scream at the child, blow up at the child
sadness	cry, withdraw
helplessness	wait until the situation is over, stay immobile
shame	leave the situation

While the first part of the exercise asks the mothers to consider their own emotions and behavioral impulses, the second part asks them to recognize the emotions of their children. Often the mothers realize that their own and the children's emotions are very similar. It is important to understand which of the child's needs are expressed by which emotions. Then it should be determined which behavior is an appropriate response to the child's emotional expressions, so that the child's need is satisfied. The group does this part of the exercise together.

Example of a completed table from Homework sheet 8a (second section)

Child's emotion	Child's need	Mother's behavior
fear	safety	calming affection
anger	to meet his own goals	calming the child down, speaking to him clearly
sadness	closeness	physical contact

Homework. The participants should read Handout 8, "Dealing with emotions." The group should discuss Homework sheet 8b, "Dealing with children's emotions." Over the following week, the participants should look out for situations in which their children show strong emotions. For one of these situations Homework sheet 8b should be filled out.

Every participant should state an individual take-home message.

Exemplary take-home message

Everybody reacts with different emotions to different situations. It is not always easy to understand one's own emotions or the emotions of others. In interacting with her child, a mother should consider and accept both her own emotions and those of her child. In this way, the mother and child can develop an understanding of one another.

2.4.9 Session 9: The importance of the body in parenting

Objectives of the session
► to sensitize the participants to their own patterns of physical reactions
► to raise awareness of the relevance of the body and body language in communication
► for the participants to develop empathy for their children's perspectives

Materials
► Handout 9: The importance of the body in parenting
► Homework sheet 9: The importance of the body in dealing with children
► stickers
► flip chart

Background for trainers
Patients with BPD often do not have a highly developed sense of their own bodies. They do not dress appropriately for the weather, have trouble standing an appropriate distance from others, or often bump into objects. They are also less sensitive to subtle physical signals from their children: often, they dress their children too warmly or not warmly enough; they put their children on their laps when they feel like it, without registering whether or not the child wishes for closeness at that moment; they are often "gruff" in how they deal with their children.

Women with BPD are often not aware of the body itself and of physical expression as a means of communication. The mothers' alienation from their own bodies is, in many cases, the consequence of violations of boundaries in their own past, and functions as a coping mechanism. However, their behavior often alienates their children from their own bodies.

This is particularly a problem because when in doubt, everyone, and especially children, tends to rely more on physical signals than on verbal signals. Since children initially have limited verbal abilities, they mainly use their bodies to express themselves, which the mothers fail to see.

On the other hand, mothers with BPD are hardly aware that they can and should use their bodies to communicate. They realize even less that they are physically superior from their children's perspective.

The goal of this session is to raise the awareness of the body as a means of communication through an experiential behavioral rehearsal, whereby the mothers take on the child's perspective.

The group will consider a special case of physical interaction between the mother and child: the interaction in a conflict situation. Such situations are particularly challenging for women with BPD, especially those who were victims of childhood abuse. They see their children as "overpowering aggressors" in physical conflicts (e.g. when the child hits the mother), and react with either physical violence or with conflict avoidance and submission. It is difficult for them to use their bodies appropriately for the benefit of the child or the protection of others. Although the examples in the behavioral rehearsal refer to physical interaction in conflicts, it should be clear that physical signals are also important in harmonious situations.

Procedure of the session

Greeting. The trainers should present the day's agenda.

Aversive tension rating. Each participant should rate her tension on a scale from 0-100.

Mindfulness exercise. The group should perform a mindfulness exercise (see H 1b Tr.).

Discussion of the homework. The participants should take turns presenting their findings from the homework (HS 8b, "Dealing with children's emotions"). The trainers should give the participants positive feedback for recognizing their own emotions. It is also important to identify the connection between emotions and (automatic) behavioral impulses. If the participants have already practiced alternative, appropriate ways of dealing with their children's and their own emotions, the trainers should encourage them to continue to use them.

The trainers should distribute the stickers for completed homework.

There is a 20-minute break.

Behavioral rehearsal for introducing the topic physical contact. The trainers should introduce the topic of the session and explain the importance of physical contact as a communication strategy in parenting.

The participants should break off into pairs. One partner should play the mother and the other should play her child. The latter should kneel at a "child's height." The task of the "mother" is to bring her "child" from point A to point B in the room, but the "child" must resist. The pairs should do this without words. The roles are then switched.

Evaluation of the behavioral rehearsal. After the rehearsal, the participants should give feedback.

First, the participants who played the role of "child" should describe their perspectives: How did I feel as a child? What convinced me to follow the mother? What did not work at all?

Next, the point of view from the "mother's" perspective is discussed: How did I feel? What did I think? What was hard for me? What were my automatic reaction patterns? What worked for me?

Drawing from this feedback, the group should elaborate on how to shape physical contact with children in conflict situations. These points should be written on the flip chart.

> **Example flip chart**
> ► eye contact
> ► making physical contact with the upper body/shoulders, instead of e.g. pulling on the child's arm; holding the child calmly
> ► pushing rather than pulling
> ► standing eye-to-eye with the child if possible, rather than guiding from above

Based on the experiences collected, the trainers should ask the participants to consider how they want to use their own bodies in future conflict situations. What is helpful for their child as well as for themselves in the long term? The trainers should write these points on the flip chart.

Homework. The mothers should read Handout 9, "The importance of the body in parenting." Homework sheet 9, "The importance of the body in dealing with children" should be discussed

within the group. The trainers should point out that the situations discussed in the session are conflict situations, but that the body also plays a role in all other interactions with the child. The task for the mothers is to observe their physical interactions with their children, and perceive the children's physical reactions. Each participant should write down what she would like to practice.

Every participant should state an individual take-home message.

> **Exemplary take-home message**
> It is helpful to be aware of one's own body language, and to consider the effect of one's own body on the child. The child's body language often reveals what the child wants and what she is not yet able to communicate verbally.

2.4.10 Session 10: Basic assumptions about parenting

Objectives of the session
► for the participants to recognize dysfunctional assumptions
► for the participants to develop a sense of perspective about their dysfunctional assumptions
► for the participants to distinguish between thoughts and facts
► to work on developing helpful assumptions

Materials
► Handout 10: Helpful and hindering basic assumptions about parenting
► Homework sheet 10a: Beliefs about dealing with children
► Homework sheet 10b: Hopes and goals for your own child
► stickers
► flip chart

Background for trainers
Basic assumptions shape our thinking and behavior, regardless of how helpful they are. Some of the problems that mothers with BPD have can be attributed to dysfunctional basic assumptions about parenting and motherhood—myths that they take for facts. A myth is an idea or assumption shaped by one's own experiences, and expresses the self-image of a person, family, or culture. These myths are generally held to be true without being facts and need individual verification.

It is not only parents with BPD who adopt dysfunctional attitudes toward parenting from their early caregivers. In most cases, however, traumatized parents lack role models and corresponding healthy attitudes towards parenting. Especially in crises or stressful situations, traumatized parents fall back on the attitudes and corresponding behaviors that they themselves experienced in their own childhoods. At the same time, they want to spare their children the pain that they themselves experienced in childhood and make everything better. This tension often leads to feeling overwhelmed and insufficient. It is often a relief to put one's own demands and convictions into perspective.

Procedure of the session
Greeting. The trainers should present the day's agenda.
Aversive tension rating. Each participant should rate her tension on a scale from 0-100.
Mindfulness exercise. The group should perform a mindfulness exercise (see H 1b Tr.).
Discussion of the homework. The participants should take turns presenting their findings from the homework (HS 9, "The importance of the body in dealing with children"). The trainers should positively reinforce the participants' perceptions of their own body in "closeness-security situations" as well as in conflict situations. The trainers may elaborate on how a change in or conscious perception of one's own body can positively affect one's child.

The trainers should distribute the stickers for completed homework.

There is a 20-minute break.

Guided imagery. One of the trainers should lead the group in a thought exercise: "Imagine a situation in which you haven't met your own standards. This can be an argument, a situation in which you've lost control, an unfair reaction, or anything else you can think of. Really put yourself into this situation... Now think: 'I'm a bad mother.' Concentrate on this thought. Try to pay attention to how your experience of the situation changes….

Now think of the same situation again. The idea that you're a bad mother arises again. Describe the thought: 'Right now, I think I'm a bad mother.' What's your experience now? What's changed in comparison to before?"

Discussion of the exercise. The participants should briefly share their experiences when they analyze the thought "I am a bad mother" with some distance. Afterwards, the trainers should explain the principle of basic assumptions using the "glasses metaphor": "Assumptions are like the lenses of a pair of glasses. If I always wear dark, colorful, or pink glasses, then I see the world accordingly. So if I always think that I'm a bad mother, I see myself and interact with my child according to that assumption."

Introduction to the topic of basic assumptions. The trainers should distribute Homework sheet 10a, "Beliefs in dealing with children". Each participant should choose her "Top 5" assumptions, the assumptions that she believes most strongly. The group should discuss these assumptions and come up with alternative perspectives together, which the trainers should record on the flip chart.

The exercise serves to clarify that basic assumptions are idiosyncratic beliefs, rather than facts, and are not always helpful.

Homework. The participants should read Handout 10, "Helpful and hindering basic assumptions about parenting". The group should discuss Homework sheet 10, "Beliefs about dealing with children." Each participant should work with her "Top 5" assumptions and formulate helpful thoughts in response to them.

Every participant should state an individual take-home message.

> **Exemplary take-home message**
> Our thoughts and beliefs determine how we feel. There are helpful and unhelpful thoughts. It is important to question our own assumptions, and to learn how to distinguish between helpful and hindering beliefs.

2.4.11 Session 11: Self-care for mothers

Objectives of the session
► to teach self-care strategies that contribute to long-term emotional stability and satisfaction
► for the participants to find a balance between self-care and caring for their children
► for the participants to take responsibility for their own mental state
► to prevent parentification

Materials
► Handout 11: Self-care
► Homework sheet 11: Self-care
► index cards to write down helpful assumptions
► flip chart
► stickers
► hand puppets

Background for trainers
Motherhood often means putting one's own needs behind those of the child. Women with BPD often exhibit very high, perfectionistic standards for themselves as mothers. At the same time, however, they have little social support. They quickly become overwhelmed and feel that they do "nothing but survive." This tendency, combined with their limited capacity for emotional regulation, can easily lead to decompensation and/or parentification.

Therefore, it is important for mothers with BPD to use all available options for self-care so that frustration can be reduced and satisfaction increases. Many women only understand self-care in terms of short-term, pleasant activities such as watching TV, sleeping, shopping, going to a movie, spending time on the computer or going out. These forms of regeneration and distraction are important and justifiable, but they should be supplemented with self-care strategies that are effective in the long term.

In addition to mindfulness (self-acceptance) and basic physical health (eating, sleeping, exercise, abstinence from drugs), activities that require short-term discipline and planning to achieve long-term goals and increase well-being are also important. The goal of this session is to promote awareness of how to apply short- and long-term strategies of self-care and thus enable mothers to take more responsibility for their own well-being.

Procedure of the session
Greeting. The trainers should present the day's agenda.
Aversive tension rating. Each participant should rate her tension on a scale from 0-100.
Mindfulness exercise. The group should perform a mindfulness exercise (see H 1b Tr.).
Discussion of the homework. The participants should take turns presenting their findings from the homework (HS 10, "Beliefs about dealing with children"). If the participants had trouble formulating helpful assumptions, the group can help by discussing the pros and cons of their basic assumptions with the help of hand puppets (e.g. a devil and a princess). Two participants should each receive a hand puppet. One puppet should defend one of the other participants' basic assumptions, while the other should argue the alternative point of view. The

"cons" puppet can be passed on when another participant introduces a new argument.

The aim of this exercise is to help the participants develop a more helpful and/or balanced approach to their basic assumptions.

The trainers should write the key points from these discussions on the flip chart.

Each participant should write her helpful assumptions on special cards as reminders.

The trainers should distribute the stickers for completed homework.

There is a 20-minute break.

Imagination exercise. One of the trainers should lead an imagination exercise: "Imagine that today, after this session, you could do whatever you wanted for the rest of the day. You leave the group. What do you do first?"

Discussion of the exercise. The trainers should write the participants' ideas on the flip chart. Next, the trainers should explain the importance of self-care, and who benefits from it (both the mother and her child). The trainers should discuss implementation strategies and possibilities with each participant. The group should discuss short- and long-term effects of the participants' self-care ideas. The table from Handout 11, "Self-care," can be used as an aid.

Homework. The participants should read Handout 11, "Self-care." The group should discuss Homework sheet 11, "Self-care." The participants should decide what they will try to accomplish in the following week, considering possible internal and external obstacles. They should write down short- and long-term consequences at home.

Every participant should state an individual take-home message.

> **Exemplary take-home message**
> Mothers are frequently concerned with the well-being of their children, often at the expense of tending to their own needs. But it is important for a mother to take care of herself so she can be a stronger and calmer caretaker for her child.

2.4.12 Session 12: Final session

Objectives of the session
► to reinforce learning steps
► to prepare the participants for the end of the training

Materials
► index cards
► stickers
► gifts

Background for trainers
The last session should focus on resources and positive development. Most of the participants will need further support after the training. These participants can formulate their specific needs and develop plans to meet their goals (e.g. parenting training, parental counseling, childcare, DBT skills group).

Some of the participants may have difficulty performing the imagination exercise in this session. The trainers must then work to find out what is helpful and important to the participants, and what they have learned.

Procedure of the session
Greeting. The trainers should present the day's agenda.
Aversive tension rating. Each participant should rate her tension on a scale from 0-100.
Mindfulness exercise. The group should perform a mindfulness exercise (see H 1b Tr.).
Discussion of the homework. The participants should take turns presenting their findings from the homework (HS 11, "Self-care"). The group should figure out which self-care strategies worked and which obstacles got in the way. The group can discuss and develop alternative strategies. The group should analyze and distinguish between short- and long-term effects of the self-care strategies.

The trainers should distribute the stickers for completed homework.

There is a 20-minute break.

Guided imagery. One trainer should lead the following imagination exercise: "Imagine you are on a journey. We have traveled part of it together. Follow your memory back to the beginning of our time in the group. How did you start? What did you have as baggage? … Think about the path you've traveled—what obstacles did you face, what did you experience? … We are now at the end of our journey. What do you want to take with you? … What do you want to leave behind?"
Analysis of the exercise. The participants should explain the images they had during the exercise. The trainers should make sure that each participant says what she will take with her and what she will leave behind. The participants should write what they would like to take with them on index cards.
Reciprocal feedback. The participants should give each other feedback using the following

questions:

► What positive changes did I see in the other mother?

► What do I want her to take with her?

It is important that the trainers ensure that the participants do not make derogatory statements (see H 1c). Afterwards, the trainers should also give feedback to the participants.

Hopes and goals for the child. Homework sheet 12, "Hopes and goals for your own child," is distributed. Each participant should think about her hopes and parenting goals, and what she can do to reach them. The trainers should encourage to complete HS 12 at home, even though homework is not discussed the next week.

Redeeming bonus points. Before the session, the trainers should consider how they can reward the participants for regularly completing their homework. Each participant should receive a small gift (e.g. tea, a small book, etc.).

Farewell. Finally, the participants and the trainers should say goodbye to each other.

Appendix

Homework sheets and handouts

References

Homework sheets and handouts

(1) Introduction
  ► Who is participating in the group training? What will happen in the group training?
  ► Which are the risks and opportunities for mothers with BPD and their children?

(2) Mindfulness
  ► What is mindfulness?
  ► How can we increase self-awareness?
  ► How can we learn to carry out mindfulness exercises alone and with one's child?

(3) The basic needs of children
  ► What does a child need?
  ► Which basic needs are easy for the participants to fulfill? Which are difficult?

(4) Stress
  ► What is stress?
  ► How does stress look to each of us?
  ► How can one recognize and avoid stress?

(5) Stress management
  ► What skills can one acquire to better deal with stress?

(6) Structure and flexibility
  ► Children need support and structure, but also need their caregivers to be flexible in certain situations.
  ► How does this look to the participants? When do they use structure and flexibility well? What are structure and flexibility good for? How could they improve?

(7) Dealing with conflicts
  ► Every woman/mother is familiar with conflicts; conflicts are entirely normal.
  ► How can I deal with conflicts constructively?

(8) Dealing with emotions
  ► What emotions are there, and how are they related to behavior?
  ► How can we learn to appropriately perceive one's child's and one's own feelings?

(9) The importance of the body in parenting
  ► What is the importance of the body in parenting?
  ► What effect does one's body have on one's child? How can the body be used?

(10) Basic assumptions about parenting
  ► There are helpful and unhelpful basic assumptions about motherhood.
  ► Which assumptions are helpful? Which are unhelpful?

(11) Self-care for mothers
  ► In parenting, it is not only important to care for one's child, but also to care for oneself.
  ► What can mothers do for themselves?

(12) Final session
  ► The contents of each session are summarized.
  ► What helpful aspects of the training will the participants take home? What might they still want to change?

For all exercises, the participants must pay attention to what they are doing (perceive, describe, participate) and how they are doing it (concentrated, effectively, and non-judgmentally). Mindfulness is not about being able to perform the exercise particularly well, but merely about observing one's actions, thoughts, and emotions that occur.
The aim is for the participants to achieve a heightened sense of self-awareness and thus enable them to practice better self-control.

Possible mindfulness exercises for the group

▶ two minutes of only listening/paying attention to noises
▶ feeling objects with eyes closed
▶ breathing: counting every breath up to 10, and then starting over
▶ naming the color of an object in the room and letting the other participants guess what it is ("I spy with my little eye")
▶ looking at and describing "Where's Wally?" books (Handford, 2010)
▶ passing the grimace: a participant grimaces, the next participant tries to imitate her, and so on
▶ balancing a sandbag on one's shoulder/hand/head
▶ walking quickly around the room without bumping into other participants
▶ Winking: the participants form an inner and an outer circle. Those in the inner circle sit or squat, and those in the outer circle stand behind them. One person stands alone in the inner circle and tries to lure one of the sitting/squatting participants to her by winking at her. The participant standing behind her tries to hold back the person who is being lured and prevent her from escaping.
▶ playing "duck, duck, goose!"
▶ miming the properties (hot, cold, heavy, light, yucky, stinky, sticky, fascinating, slippery, etc.) of an imagined object that is passed around in the group
▶ slowly tearing newspapers and listening to the sound
▶ trying to get raw eggs to stand on their own
▶ Chair game: the participants stand behind a circle of chairs, and each participant tips the tilted chair in front of her with one hand. One person claps out a beat: one clap means that all the participants move one place clockwise and take over the next tilted chair; two claps means switching directions. The goal is to prevent the chairs from falling over.
▶ All the participants hold a cloth, pull it until it is taut, and try to roll a ball in circles in the middle of it.
▶ Pair exercise: two participants stand across from each other, and each holds her palms together. They take turns trying to catch/grab the clasped hands of the other participant.

Individuals with borderline personality disorder suffer from significantly higher aversive tension than those who suffer from different or no mental disorders. This tension is accompanied by difficulty with identifying and regulating emotions, absorbing and processing complex information from one's social environment, and systematic acting. The tendency to dissociate also increases as tension grows. Women with BPD often have no access to their feelings or feel nothing at all (like a robot). When they do feel something, it is frequently so intense and unpleasant that they want to get rid of it, e.g. through distraction, increased tension or impulsive behavior.

Women with BPD frequently do not have a good opinion of themselves, and are very negative about or doubt the validity of what they perceive ("I have no reason to feel this way"). These judgments contribute to further tension.

Studies show that people start to lose control over their actions above a subjective tension level of 70 (on a scale of 0-100). Since tension in individuals with BPD can be triggered very quickly, it is extremely important to learn to recognize early warning signs for this loss of control and counteract them with appropriate skills. In Dialectical Behavior Therapy (DBT), it is assumed that it is helpful to use different skills (e.g. mindfulness, appropriate methods of dealing with emotions, and stress tolerance) depending on the degree of tension. In the case of severe dissociation, crises, and acute danger of an individual losing control, emergency skills can help reduce the individual's tension to such an extent that planned thinking and action is possible again (see Emergency Tool Kit in Linehan, 2015). The more those skills are practiced, the easier it is to deal with difficult situations.
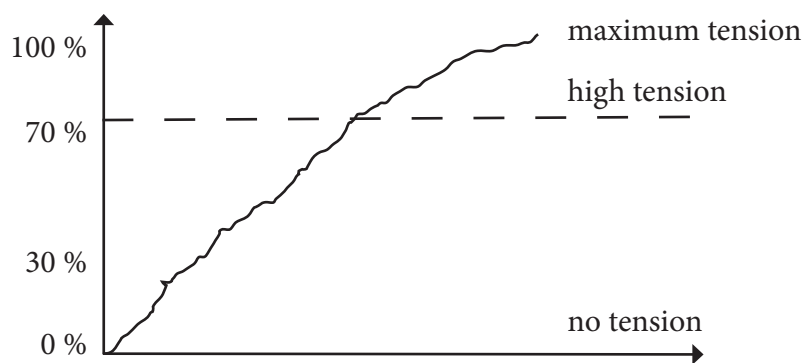
Graph: Tension/Stress curve after Bohus & Wolf-Arehult (2013)

> **Case study**
>
> Jenny had her first child at age 19. Both her parents were alcoholics and could not appropriately care for their daughter, so she was raised in a foster family. Jenny did not feel very loved by her foster parents; she was a "problem child" and had a lot of problems. After her second suicide attempt, she met Martin in a clinic and fell head-over-heels in love with him. Three weeks after their first kiss, she was pregnant. The child was not planned, but both Jenny and Martin were very excited. The dream of having a healthy family seemed close at hand. They wanted to do everything differently from how their own parents had done it.

Developmental model of Borderline Personality Disorder

Biological factors. Children of mothers with BPD are at a higher risk of developing the disorder themselves. The basis for developing BPD is partly inherited: this means that the children, like their parents, are often very sensitive, prone to stress, and difficult to calm down. This cannot be changed.

Invalidating environment. If the child experiences that she is wanted, that she is loved, and grows up in a safe environment in which her needs are attended to, then she can grow up healthy despite her predisposition—in fact, she can learn to benefit from her sensitivity.

If, however, the child's parents or caregivers constantly create the impression that the child's ways of thinking, feeling and behaving are incorrect, that no one is interested in what she needs, and that there is no one who will listen to her, understand her, or protect her, the child is raised in an "invalidating environment". An invalidating environment leads to increased sensitivity in the child, and impairs her ability to deal with stress. Besides the biological factors, it is a second risk factor for developing BPD.

Parents with BPD who were themselves raised in invalidating environments have particular trouble providing their children with a validating environment, but they can learn to do so.

Particular difficulties and challenges for mothers with BPD

Compared to "average" mothers, mothers with BPD are more prone to feelings of dissatisfaction, inadequacy, and stress when dealing with their children. They often change their places of residence, partners, or jobs. Additionally, mothers with BPD often experience extreme and inexplicable mood swings, while at the same time often having vulnerable/temperamental children who place particular demands on them. Therefore, it is a great challenge for these mothers, who are already overwhelmed with their own feelings, to attend to their children.

Experiences of invalidation

Interaction

Biological predisposition

Temperamental, willful mother is stressed, pressed for time, feels misunderstood, and wants to assert herself

Child disobeys even more

Mother reacts angrily "You don't have the right to make such a fuss"

Temperamental, willful child feels misunderstood and wants to assert herself

Further invalidating experiences for the mother and child; more stress and tension
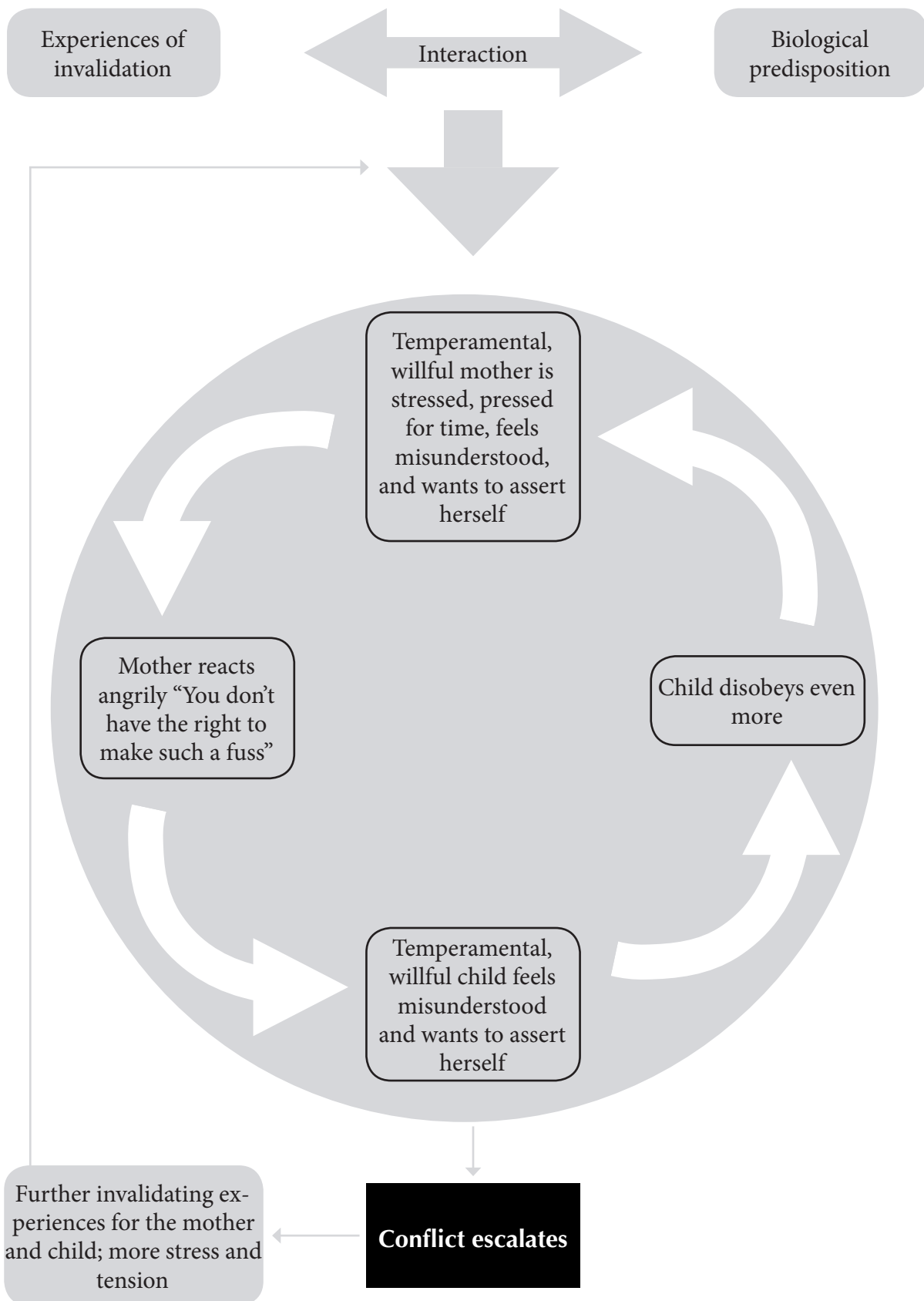
Conflict escalates

Figure 1: Conflict between mother and child (mother wants to leave the house, child does not want to get ready for school)

Risks to children

Various studies have shown that children of mothers with BPD are more likely to suffer from various problems including: persistent crying as infants, difficulties calming themselves down, and having an "absent look". Toddlers and preschoolers of mothers with BPD are very afraid that their caregivers will abandon them, fear danger when being with their caregivers, and exhibit a shameful self-image ("I'm a bad kid"). Often, children of parents with BPD take on the role of the parent in their parent-child relationship (role-reversal). This can mean that they feel overly responsible for the well-being of their parents and take on the corresponding responsibilities (e.g. cheering up, protecting or comforting their mothers, or looking after their siblings, instead of addressing their own needs, like playing with friends). Overall, these children are at high risk for developing emotional and behavioral problems from infancy to adolescence.

These behavioral problems can worsen the mother-child relationship: the mother reacts in an increasingly helpless, aggressive, and stressed manner, and the child feels increasingly rejected and unloved. The goal of this training is to break this vicious cycle.

Do you notice something similar with your child/children? Is there other behavior in your child that worries you?

_____
_____
_____
_____
_____

Goals of the training

(1) Learning about and dealing with children's behavior. Women who have grown up under problematic circumstances often do not know what appropriate and normal parenting behavior looks like, and it is hard for them to properly assess their children's behavior – e.g., when the children cry, disobey them, or say they are afraid. Mothers with BPD often do not know how to interpret the situation and what they can do. As a result, they might not react properly, and then become stressed when their reaction leads to problems with their children.

Can you think of your own example of this?

_____
_____
_____

→ **Goal:** To learn to properly assess children's needs, behavior, and forms of expression; to develop positive and non-violent parenting strategies.

(2) The meaning of rules and structure. Women with untreated BPD often find it difficult to create and maintain a stable environment for their children. They often move apartments, have problems in their relationship with their partners, and lack structure and routine in daily life. They also have trouble putting a predictable and understandable system of rules and boundaries for their children in place.

Do you recognize this from your own life? Write down an example here.
_____
_____

→ **Goal:** To create a safe and stable home environment with predictable rules, consequences, and routines; to reduce stress for the mother and the child.

(3) Dealing with stress. Mothers with BPD often experience a high level of tension and susceptibility to stress, and tend toward impulsive behavior (e.g. screaming and hitting). This inclination toward aggressive reactions applies not only to interactions with their children, but to disputes in general (e.g. with a partner). The child often cannot understand or predict her mother's testy or violent reactions.

Do you recognize this from your own life? Write down an example here.
_____
_____

→ **Goal:** To better deal with stress

(4) Dealing with one's child's and one's own emotions. Women who do not cope with their own feelings have trouble appropriately dealing with their children's feelings. Their children thus have trouble predicting their mother's reactions:
► In one moment a mother can be intensively involved with her child, and in the next moment decide her child is too much for her (over-involvement and under-involvement).
► In one moment she puts her child under pressure, and in the next moment she feels under pressure herself, brushes the child off and leaves the child to her own devices.
► In one moment she is affectionate; in the next, hostile and cold.
► In one moment she rewards her child for doing something; in the next, she punishes her child for doing the same thing.
► The child is told that she is not supposed to act a certain way, that she has no reason for her feelings or behavior. She is harshly judged for feeling or acting in a certain way (invalidation and misinterpretation of the child's behavior).
► The mother is often insensitive in her behavior and way of speaking with her child. She is frequently critical, pushy, and frightening.
► The child is often treated as a friend or a parent (role-reversal).

Do you recognize this from your own life? Write down an example here.
_____
_____
_____

→ **Goal:** To develop predictable and positive reactions to children's emotions; to better regulate one's own feelings

Quiz question: Which two factors play an important role in the development of borderline personality disorder?

(1) Each mother with BPD who is seeking help wants to be a good mother.

(2) She must accomplish more than she believes she can.

(3) She often did not cause her own problems, but she must find a way to overcome them herself—this is unfair.

(4) She is responsible for giving her child what she often did not receive herself.

(5) She must learn new behavior in many important areas of life.

(6) She needs proper support.

(7) Her child especially needs love, protection and support.

(8) The child's development is in danger if the mother does not learn to correctly meet her needs.

(9) The child directly benefits from her mother's improvement.

(10) Therapists working with a mother with BPD and her children need to work together collaboratively as a team.

Feedback is an important aspect of the rules of communication in groups, and constitutes a basic form of social learning. It is important to follow these feedback rules in order to avoid insulting others.

! A general rule: Give constructive feedback!

This means:
► Give feedback on specific behavior in specific situations, not on speculation, interpretations, or someone's personality traits. (e.g. "It was hard for me to listen to you just now, because you were pretty agitated and speaking really loudly" versus "You're always so aggressive!").
► Give both praise and criticism — but praise always comes first!
► Present your own perspective as your own perspective (e.g. "I have a different idea about how much TV is ok" versus "I like/don't like what you're doing"). Don't use any generalizations (e.g. "One shouldn't do that").
► Feedback is for the benefit of someone else, and should be helpful to him/her.
► Only give feedback when the other person is ready to receive it.

! When you receive feedback, listen quietly—don't try to justify yourself!

Date	Was the homework completed?	Was the handout read?

Case study

Jenny really strove to do everything right with her child, but she was starting to feel like a robot that just performed tasks. It particularly unsettled her that she often did not feel love towards her child. Instead, she was frequently annoyed when her baby wanted something, and brushed him off. Even when everything was going well she felt no joy. Most of the time she couldn't say what was wrong with her, except when she was angry or distraught. When she felt something like sadness or exhaustion, she thought it was wrong – she didn't have a reason to be sad or tired, and other people don't make such a fuss, she then thought.

Mindfulness can be a great help in coping with stress, increasing your satisfaction, getting a better grip on your life, and developing good relationships with your child and others. Mindfulness is the basis for all skills taught in this training. Only a person who recognizes what is happening can influence it.

What is the purpose of mindfulness?
Mindfulness exercises are an invitation to take a whole new path in dealing with yourself and others. Mindfulness is about:
► understanding and accepting yourself, rather than judging
► accepting what can no longer be changed, instead of brooding over it
► taking a deep breath between the emergence of a feeling and the resulting action
► recognizing the difference between thoughts and facts instead of taking your momentary thoughts and feelings as the absolute truth
► addressing unpleasant facts, instead of avoiding them
► doing what is necessary and possible in the moment, instead of thinking about past or future obstacles and failures
► observing your child in an interested and caring way, rather than judging him based on how you think he should be.

Does this sound hard? It is—especially at the beginning, it is hard to constantly motivate yourself to practice. Thoughts often arise, such as "It doesn't matter; I can't do it; I have more important things to do; I can't stand this; what's the point of all this anyway…"
These thoughts are completely normal. After a few weeks of regular practice, you will start to succeed. Have patience and keep practicing!

Practicing mindfulness
You can practice mindfulness by constantly turning your attention to the following:
► What is happening right now? What is going through your head? What do you feel? What would you most like to do? What do you feel in your body?

► How can you observe what is happening inside and around you without reacting to it immediately? By accepting what you observe even if you don't like it, because only when you investigate and understand the problem can you find effective ways to act.

Mindful observation is directed internally to your bodily sensations, feelings, thoughts, and behavioral impulses, as well as externally, to what you perceive with your senses—what you see, hear, taste, smell and feel. In dealing with children, this means: you are mindful of both yourself and your child.

> **Case study**
>
> Jenny's baby cries at night. She doesn't like it at all. She feels tired, distraught, helpless, and angry. No matter what Jenny does, the baby cries more. Jenny thinks, "I can't do this anymore! Why won't you be quiet!" Most of all she wants to scream, shake her baby, or go to her bed and pull the covers over her head.

What would be a mindful reaction? Check it off.

Jenny goes to her room, lets the child cry, puts on her headphones and listens to a relaxation CD.	
Jenny realizes what is going on inside her, and what she wants to do. She waits, and watches what happens next. Then she may see: her child is turning away or stretching out his arms.	
Jenny thinks: "It's good to let off steam!" and hits a pillow.	

Mindfulness in relationships

Having a mindful attitude in relationships means that you perceive what impulses your counterpart triggers in you, but you do not have to follow those impulses. You can have an open and calm attitude with your counterpart, and can react effectively to him/her. A mindful attitude thus improves your relationship and your well-being. It helps you to better control unfavorable responses, as well as to better understand yourself and others.

> **Case study**
>
> Jenny's son was now three years old. She picked him up from daycare. She was looking forward to it, and expected him to be excited to see her. But he did not greet her or even look at her; he ignored her. Jenny was both disappointed and worried.

What would be a mindful reaction? Check it off.

Jenny ignores her son and pays attention to her breathing.	
She explains to him that she is disappointed by his behavior.	
She waits first and observes her son. Then she asks: how was your day?	

Often, being able to trust someone with his thoughts and feelings is enough for a child to feel understood and accepted. Then he can calm down and learn that feelings pass, and are a part of life.

Mindfulness with children

Mindfulness is the basis for parental sensitivity in dealing with children. This includes the ability:

▶ to observe how your child expresses himself and behaves (that is, pay attention to him, listen to him, and play with him instead of getting distracted by cellphones, computers or other things)

▶ to understand the child's signals and interpret them correctly; to recognize his needs; to be as unaffected as possible by your own state when considering that of the child (when I'm feeling warm, I can't imagine that my child could be freezing; when I'm full, it is not easy for me to notice that my child may be hungry; when I'm bored, I immediately think that my child is also bored)

▶ to react directly and appropriately to the child's comments (that is not to fulfill all the child's wishes, but to show that you care about what he has to say and take him seriously).

If we understand both the child's and our own reactions better, we can stay calmer and act more effectively.

Mindfulness helps us to let go of our own painful experiences, to react more openly to new situations, and let the child have his own experiences.

Our perceptions may change with mindfulness: we may start to see things differently than

> **Example**
>
> Susan's four-year-old daughter was the only one not invited to another child's birthday party. It makes Susan think about how she always felt excluded as a child…how she really wanted to belong, but never did. She starts to feel sad and angry—what if the same thing will happen to her daughter? She perceives this feeling, does not say anything at first, and watches how her daughter reacts. She sees that she is sad, but the next moment she is thinking of something entirely different.

we are used to. In the long run, this is usually very liberating, but at the beginning it is also unsettling and unpleasant. It is like everything that works in the long term, but is unfamiliar or uncomfortable at first: you need patience and determination. In the moment, it is usually easier to follow your usual habits. However, continuous mindfulness practice helps you to reduce and regulate your internal tension.

Quiz question: Do mindfulness exercises always work right away?

Choose one exercise for each day and take conscious time to do it. It is completely normal for your mind to stray or to find the exercise boring or unpleasant. Take note of your feelings, thoughts, and impulses and always bring your attention back to the exercise. You will always find yourself judging: "Did I do the exercise right? What should it be about? This is silly, I can't do it, etc." Be patient and stick to the task, even if only for a few moments a day.

Consciously perceiving with the five senses
(1) Exercises that you can perform alone or with older children:

- ▶ Mindfully eat a raisin (or a berry).
- ▶ Observe a plant.
- ▶ Perceive noises in nature.
- ▶ Touch an object (such as a stone).
- ▶ Smell a flower.
- ▶ Observe your own breathing.
- ▶ Walk mindfully – feel your feet on the ground.

(2) Exercises with babies:

- ▶ Look at your baby, taking note of every detail.
- ▶ Feel your baby when you hold him in your arms or caress him: his temperature, skin, clothes. Perceive the baby's smell.
- ▶ Listen to the baby.

(3) Exercises with older children:

- ▶ Watch your child while he plays. Take note, without judging, of exactly what he does.
- ▶ Watch your child while he sleeps.

Do an activity from this list for a limited amount of time every day. Try to stay focused on it as much as you can. Always return to the exercise, even if you get distracted by thoughts, feelings, or external stimuli.

List of pleasant activities to do with young children or babies
(1) Play finger games.
(2) Sing to or with your child.
(3) Throw pillows on the floor or have a pillow fight.
(4) Cook with your child, e.g. let your child stir the pot.
(5) Let your child feed you.
(6) Hide things (e.g. the teddy bear) and let your child look for them, or let the child him self hide.
(7) Run together on a sports field.
(8) Draw things that your child can color in; draw, paint, or finger-paint together.
(9) Make things: decorate candles, make woolen dolls, decorate or paint with leaves.
(10) At the child's bedtime, lie down with your child to talk about the day's events.
(11) Make a fort together from cardboard boxes, blankets, etc.
(12) Make soap bubbles.
(13) Go to the petting zoo together.
(14) Skip through a meadow together.
(15) Sing a song at the table before eating a meal.
(16) Ride bikes together; take your child on a bike tour (with the child in a bike seat or bike trailer).
(17) Play horses with the child on your lap.
(18) Watch your child play.
(19) Listen to music together.
(20) Play on swings.
(21) Go out for ice cream.
(22) Watch your child play on the playground; play with your child.
(23) Cuddle with your child.
(24) Decorate for a holiday together, e.g. for Christmas or Easter.
(25) Fly a kite.
(26) Float wooden or paper boats down a stream.
(27) Feed/watch ducks.
(28) Go ice skating/inline skating.
(29) Bake cookies or cakes together; invent recipes.
(30) Look out the window.
(31) Take a bath.
(32) Lay together in a hammock.
(33) Read to your child.
(34) Make paper lanterns.

(35) Collect chestnuts.

(36) Set up a dollhouse.

(37) Attend a parent-child gymnastics class.

(38) Decorate cookies.

(39) Look at baby pictures or other photo albums.

(40) Go to a puppet theater; play puppets.

(41) Plant something; tend to a garden.

(42) Play memory games.

(43) Do puzzles.

(44) Role-plays: play "Make-believe…" or "Be your favorite animal".

(45) Build something—bird houses, etc.

(46) Visit an adventure playground.

(47) Invent a game.

(48) Kid around.

(49) Invent a secret language.

(50) Fish with homemade rods for fish or rubber duckies.

(51) Go to a department store together (only works if you are relaxed and don't have to buy anything; best to go to the clothing department, to avoid breaking things): ride the escalator, let your child press the elevator buttons, hide between the clothing racks.

(52) Put on children's makeup.

(53) Make a collage with old newspapers.

(54) Make popcorn and watch a movie.

(55) Go for an evening walk with a flashlight.

(56) Lay around and do nothing; make up stories.

(57) Go to the zoo.

(58) Go to a children's theater/musical.

(59) Go for a walk in the woods.

(60) Jump rope.

(61) Make sandcastles.

(62) Take pictures.

(63) Play hide-and-seek.

(64) Dance.

(65) Play "I spy with my little eye…".

(66) Give your child a piggyback ride around your home.

(67) Play catch.

(68) Let your child wear your slippers and clomp around the house.

(69) Take plastic dishes out of the cupboard, stack them and put them back.

(70) Play trains.

(71) Race toy cars.

(72) Play with blocks.

(73) Make music (drums, rattle, etc.).

(74) Make animal sounds.

(75) Walk like animals through the house (waddle like a penguin, jump like a bunny, prowl like a tiger, etc.).

(76) Tickle each other.

(77) Play-fight.

(78) Hop.

(79) Play ball.
(80) Collect leaves.
(81) Look at a picture book.
(82) Take a midday nap.
(83) Go sledding.

List of pleasant activities to do with babies
(1) Massage your baby's body with almond oil; give it a "baby massage".
(2) Lie next to your baby and "chat" to him.
(3) Sing to your baby.
(4) Play finger games; sing your baby nursery rhymes.
(5) Dance with your baby.
(6) Walk around with your baby, show and explain things to him.
(7) Take your baby on a walk in the stroller.
(8) Go to a baby group, or a baby or children's gymnastics class.
(9) Take your baby to a baby swimming course.
(10) Talk nonsense.
(11) Go in the bathtub with your baby.
(12) Look out the window.
(13) Make the baby laugh.
(14) Fan your baby's face.

Day / Situation	Exercise / Duration	Completed?	Obstacles / Experiences

> **Case study**
>
> Jenny believed that the only things her baby needed were a dry diaper, something to eat, and a place to sleep. If she provided these, she believed that the baby had no reason to cry. But the baby cried nonetheless. Jenny thought the baby was only crying in order to annoy her, or that he was suffering from a terrible and unknown disease. When her child ate less than usual, she believed he would starve, and forced a spoon into his mouth. Sometimes she would fight with her partner in front of the baby. She would feel guilty about it, but then wouldn't feel so bad, because the baby didn't understand anything yet.
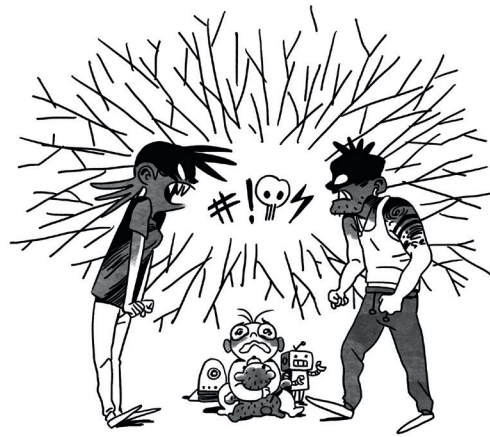
After birth, children are completely dependent on care, nourishment, and protection from their caregivers. Even when they grow older, they are still dependent on us for quite a while. Children are able to express what they need from a very early age, but since they cannot yet speak and only later slowly learn to communicate, they rely on their caregivers to understand their signals correctly.

Basic rules of care for young children

There are a few basic rules of care that are vital to creating a healthy environment for young children. You already know most of them:

Nutrition. Regular and age-appropriate nutrition is important. In the first months, babies should be breast-fed or given baby formula in the appropriate doses. Older children ideally receive five meals a day: breakfast, lunch, and dinner (one of which should be a warm meal), and two snacks between meals (fruit; yogurt). They should also be sufficiently hydrated with unsweetened drinks. Meals should be eaten in a quiet, friendly atmosphere without distraction (TV, cellphone), and if possible, with adults. Essentially, a child should decide how much she wants to eat, and the mother should decide what she puts on the table and when.

Sleep. A child needs a safe and clean place to sleep, which must have an adequate guard railing if necessary. A sleeping bag is useful for 0-1-year-olds. The air in the room should be fresh, the temperature not too hot and not too cold. Whether the child sleeps in her own room or her parents' or mother's bed depends on several factors. Having her own permanent sleeping area and regular bedtimes help the child develop healthy sleeping routines. The home should be child-friendly, with space for the child to play and rest.

Clothes. The child's clothes should be clean, comfortable and weather-appropriate. Her shoes should fit, and also be weather-appropriate.

Bodily and health care. When a child's diaper is full, it must be changed right away so as to prevent skin irritation. Pay attention to the child's smell—that means washing a baby regularly, and helping toddlers to regularly bathe, brush their teeth, and avoid candy and sugary drinks. The child must be brought to all her doctor's check-ups and given all the necessary vaccinations; in case of illness or emergency, bring the child to the doctor immediately. It is equally important

to make sure the child eats healthily, exercises regularly, and gets enough fresh air.

Supervision and protection. Sources of danger for children can be: electrical sockets, toxic substances, trash, shards of glass, loose stairs, unlocked windows, stoves, medicine, smoke, and traffic.

Long-term dangers include spending too much time watching TV, playing video games, or using the computer. Young children do not need to use the TV or the computer. Older children should watch—if they watch TV at all—a maximum of 1-2 child-friendly programs a day, which should be chosen by their caregiver.

Children only learn to recognize danger through experience, and through the examples and guidance from their parents. Until children can learn to protect themselves, their parents must protect and supervise them. A young child should therefore not be left home alone, even for a short amount of time or while she is sleeping.

In addition to potential physical threats, leaving a child home alone puts her at risk of psychological damage. A young child has no concept of time—she cannot conceive that something exists when it is not "there." It only gradually learns through experience that her mother still exists when she is absent. If a child is left alone for a short time—for the child, an eternity—she feels completely abandoned and helpless, gets very afraid, and may lose confidence that she is safe.

The mother does not always have to supervise the child—other adults (fathers, nannies, grandparents, friends) may do so as well. It is very beneficial to the child to build reliable relationships with different people, provided these people know how to meet the child's needs.

Other needs

While their basic physical needs are quickly recognizable, children also have other needs which require a higher level of mindfulness and attention. It is not always possible to assess these needs correctly. The following are some recommendations on how to help a child develop by recognizing and satisfying these needs:

Emotional care. How safe and self-confident a child feels, how she deals with her feelings, and how she develops her relationships depends essentially on the quality of the emotional care she receives.

Physical contact and personal space. A child needs age-appropriate and loving physical contact regularly—not just when her caregiver is in the mood for it. Children like to test their strength in a playful way, be lovingly cuddled, and held when they're sad. At the same time, a child also needs personal space, which she communicates by turning her head away, reacting reluctantly or tensely to physical contact, or walking away. This is normal, and the child's need for space should be respected.

When the child is with adults, she needs attention—regular eye contact or short, friendly verbal communication. She does not need to be the center of attention all the time, but she must feel that she belongs and is noticed.

Feelings. Mothers should repeatedly express pleasant feelings like joy, love, and pride with their child. But they may also address other feelings, such as anger, grief, and disappointment, so the child learns to appropriately deal with difficult feelings, too.

Appreciation. Even when a mother has problems and conflicts with her child, her basic attitude should be appreciative: "No matter what you do, I love you as you are." The mother should make the child a natural part of her daily planning process, taking into account the child's interests (by planning child-appropriate activities).

Autonomy, support, and exploration. Once the child turns one, she starts to develop a will

of her own, and therefore starts to recognize limits on her freedom. This is initially frustrating for the child—she is like a queen that has been pushed off of her throne. The child also makes the devastating realization that her mother is not always kind and loving, but also scolds her and sets boundaries.

At the end of the second year of life, the child has the overwhelming realization that there are things that she "wants", and things that she can do herself. She can purposely influence her surroundings. Naturally, she then wants to try this, and does not see why she should be held back from doing so. In this stage, the child needs understanding and patience but also support, guidance, and clear rules.

In order to develop healthy self-confidence, the child needs to learn that she is loved and accepted even when she wants something that her mother does not. She needs encouragement and regulated freedom for her attempts to explore the world.

A mother must learn to cope with the fact that her child will sometimes get angry or misunderstand simple things for "no reason". She might get the idea that her child does this deliberately to make her life harder, but this is not the case. It is important to put oneself in the shoes of a two-year-old in moments like this: What is it like to be so small, to be unable to do so much, and to have to depend purely on powerful and large adults who determine everything?

Structure and flexibility — finding a rhythm. All organisms follow rhythms to survive and stay healthy. For humans, for instance, these rhythms consist of: inhaling - exhaling; sleeping - waking; eating - digesting; tension - relaxation; doing activities - resting; work - leisure; being alone - being with others; deciding for oneself - compromising. Some of these "rhythmic needs" are innate; they can vary greatly depending on biological make-up, age, and living situation. A child's "rhythmic needs" often conflict with everyday demands or the needs of adults. This is why it is important to find a daily structure that suits your own as well as your child's rhythm. Rules, rituals, and set times for sleeping, getting up, eating, resting, and playing provide guidance, reliability and safety for both adults and children.

Protection from violence and ill-treatment. Children need—like all living creatures— non-violent and loving relationships. Beating, shaking, screaming, threatening, humiliating, intimidating, insulting, withholding affection, locking a child in a room, letting a child cry, causing fear and anxiety, and all kinds of unpredictable punishment are forms of psychological and/or physical abuse, especially when they happen regularly. The child cannot comprehend these forms of punishment, and will be greatly damaged by them in the long run. But the child needs not only protection from violence, but also a nonviolent environment in which to grow up. Witnessing violence between adults or siblings can have a similarly damaging effect on the child.

So why are children still being mistreated all over the world? Some possible reasons include:

▶ Caregivers are helpless, and they don't know what else they can do. No way of influencing their children that they have tried has worked (e.g. talking to or distracting their children).

▶ Caregivers believe that the alternative to punishment is to let the child have her own way on everything; that the child will then not learn anything and will get into danger or run wild.

▶ Caregivers are angry, and have no control over their own behavior.

▶ Parents have experienced violence from their own parents, haven't learned how to solve conflicts peacefully, and feel overwhelmed and helpless in conflict situations.

When children experience violence in their home environment, they learn that violence is "normal". This increases the risk that they will be violent themselves or be victims of violence. The best protection from violence is a non-violent environment with stable and secure

relationships.

The small difference between needs and desires. Do children need all the new toys, the latest technology, unlimited television and computer consumption, sweets, and brand clothing that they want? Children are no different from adults—they want what others have. If they do not get it, they get frustrated. Often, it is not so easy to distinguish between what a child needs in order to develop healthily, and what she only wants in the moment. Conversely, children do not often know what is good for them: vegetables, exercise, brushing their teeth, going to bed early.
One help in determining a child's needs rather than her desires can be to imagine the future: What is perhaps unpleasant right now, but important in the long term? Children lack the ability to act with foresight—they follow their moods, and gradually learn to take more responsibility for themselves – also by following their parents' examples.

Quiz question: What is an appreciative attitude toward a child?
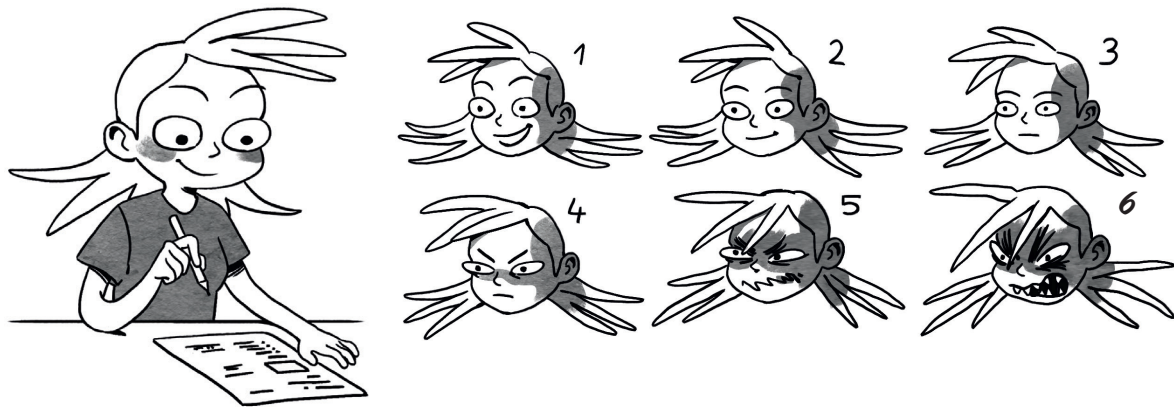
Basic need	What works especially well?	What needs to be improved?	Self-evaluation scale 1-6
nutrition			
place to sleep, child-friendly home, place to play			
clothing and bodily care			
protection and supervision			
health and medical care			
emotional care			
rhythm and structure			
non-violent environment			

Scale: 1 = very good, 2 = good, 3 = satisfactory, 4 = sufficient, 5 = poor, 6 = insufficient

> ### Case study
>
> Life was not easy for Jenny. Martin disappeared from her life and she had to deal with everything alone. Her son was now going to daycare while she had a job in a supermarket. Because she was so exhausted, she often could not get out of bed in the morning, and would then have to hurry to get her son to daycare and get to work on time. This constant hurrying put Jenny under a lot of pressure, and often caused her to react to her son more gruffly and aggressively than she wanted—sometimes she was really mean to him.

What is stress?

"Stress" generally means an organism's reaction to burden. Each person's experience of stress is different, and depends on many factors. We assume that in the early history of humankind, stress was a useful response to external dangers, such as attacks from wild animals or enemy tribes, hunger, or cold. In order to survive, a mother could not just sit in front of the cave and relax—she had to be alert and ready to defend against or escape from danger, or concentrate on finding food and shelter. In moments of stress, an organism's body reacts by enabling the highest amount of muscle activity that is required for survival.

Unfortunately, our biological system has not optimally adjusted to modern times. In our everyday lives, we hardly need our muscles to deal with such demands or threats. We get our food from the supermarket and live in warm, centrally-heated homes. It is not helpful—it is probably even harmful—to react to an unfair boss, computer problems, a crying baby, or a traffic jam as if it were an attack – by fighting back or fleeing.

Physical reactions. Our automatic physical reactions to stress are still the same as they were in the Stone Age:
- cardiovascular system is activated (heart beats faster, more blood is pumped through the muscles)
- muscle tone increases (muscular tension)
- sugar and cholesterol levels rise
- intestinal activity is affected (diarrhea or constipation)
- perception is narrowed down and focused on signs of danger or threats (tunnel vision)

How does stress develop?

Stress can be triggered by many circumstances or events, e.g. "critical life events" (separation, the birth of a child) or everyday burdens (conflicts, excessive demands). The intensity of each stressful situation depends on the individual's personal stress intensifiers (attitudes, evaluations, and demands). Stress triggers and personal stress intensifiers often influence each other. A person's response to stress is largely dependent on her personal stress intensifiers (see image on page 3, H4).

Prolonged stress

All of these reactions are harmless if they stop after a short time and are followed by a recovery phase (e.g. when the source of danger has disappeared, the tiger has been killed, or the problem solved). However, some living situations—such as when a person is overburdened or lacks opportunities to rest—can create chronic stress.

Consequences. Consequences can be:

► permanent tension, pain, cardiovascular problems, gastrointestinal problems, sleep disorders

► constant strain and exhaustion due to permanent "preparedness for danger"

► impaired immune functioning

► inability to think straight, tendency for involuntary behavior that sustains or intensifies stress (e.g. impulsive behavior such as throwing things at the wall, screaming at or beating the child)

► decreased bodily awareness (e.g. of pain, tension) that obstructs self-care and sustains or intensifies stress.

Evaluations and expectations

The stress brought about by a given situation often has less to do with the situation itself, and more to do with how we evaluate it, what we expect from it, and what we fear from it. It is crucial how competent we think we are to deal with the situation, and whether we remember successful experiences rather than ones that resulted in helplessness or failure. Our own standards are also important: what do I expect from myself (e.g. perfection, exceptional achievement, to be like others)?
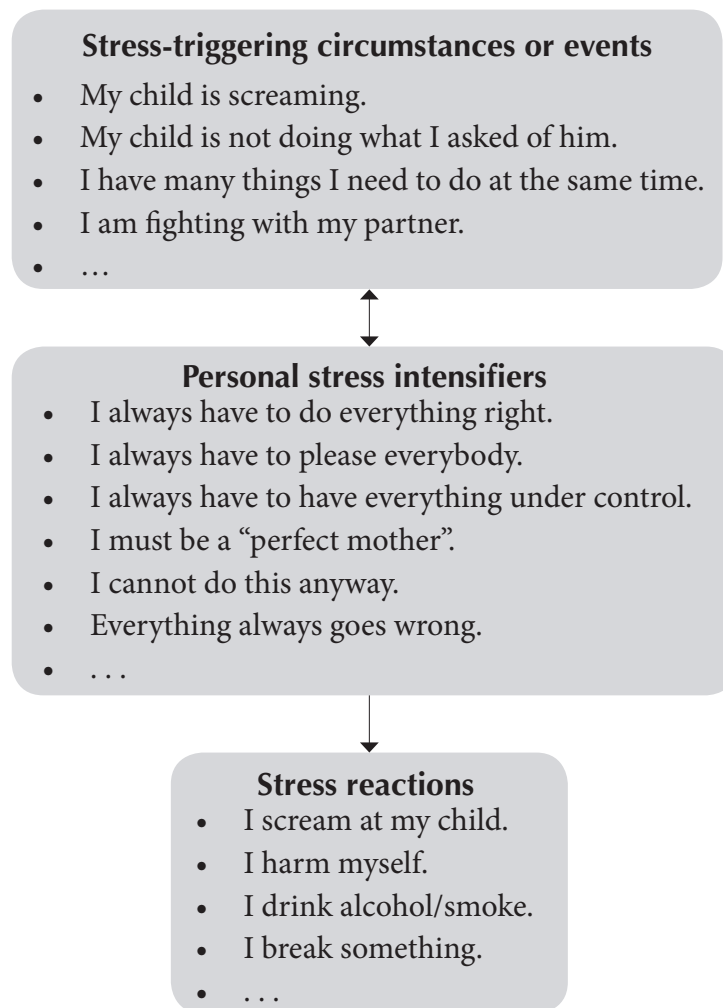
Stress-triggering circumstances or events
- My child is screaming.
- My child is not doing what I asked of him.
- I have many things I need to do at the same time.
- I am fighting with my partner.
- …

Personal stress intensifiers
- I always have to do everything right.
- I always have to please everybody.
- I always have to have everything under control.
- I must be a "perfect mother".
- I cannot do this anyway.
- Everything always goes wrong.
- . . .

Stress reactions
- I scream at my child.
- I harm myself.
- I drink alcohol/smoke.
- I break something.
- . . .

Figure 2: Stressmodel

Example

Imagine a person running through a very dangerous jungle. If you told her to relax and pay attention to the beautiful flowers instead of to the sound of cracking twigs, she would find it rather absurd.

The real dilemma emerges when the person finds herself in the Botanical Gardens rather than the jungle, but her brain still signals "danger" at the sound of every crack. She is not only tense and unable to enjoy the beautiful flowers, but also sees that something is wrong with her, as everyone else seems to be able to enjoy the situation.

Of course, it is also important whether a person has learned how to behave in a difficult situation, and whether she has the tools available to effectively solve a problem. Individuals with BPD are more likely to be "on guard" because they have had to learn to survive under persistently difficult internal and external conditions, due to their life experiences and/or their biological make-up. Their neurobiological systems and their worldview are oriented toward threats, making it very difficult for them to calm down.

Research has shown that individuals with BPD on average suffer from much higher tension, become stressed much more quickly, and return to their pre-stress state much more slowly. What does that mean for mothers like Jenny?

Effects of stress on the mother. Stress has clear effects on Jenny's behavior and her relationship with her child:

► She gets annoyed more quickly, tends to more quickly lose control over her behavior, and reacts more impulsively.

► She more readily perceives her child's behavior as directly hostile towards her.

► She more readily feels helpless and overwhelmed, may react more frantically or passively, which further intensifies her stress.

► She tends to "drift" (dissociate) when she is in a very tense state, and her child can no longer reach her.

► She is less in the position to notice and express pleasant things and loving feelings, since her perception is completely oriented toward unpleasant (threatening) things.

It is perfectly normal for parents to be stressed from time to time in the presence of their children—children learn in such situations and must not be coddled.

Effects of stress on the child. However, if parental stress and tension become normalized, problems for the child can arise:

► The parent's persistent tension is transferred to the child, who in turn behaves more aggressively or avoids contact in order to protect himself. He reacts to stress with similar symptoms as his parents, but does not have the ability to understand or cope with the situation.

► The child learns that "the world is a dangerous place." He might learn to deal with dangerous situations very well, but does not learn how to feel happy, safe, curious and open, and how to trust other people.

Quiz question: Are the situations that cause stress the same for everybody?

The following examples should help you to better assess stressful situations. You can complete the table with your own examples.

Which stressful situations do I recognize?	They stress me out from (0) "not at all" to (4) "completely"
I oversleep, and have an appointment with my child (e.g. daycare).	
My child has a tantrum in public.	
I have a fight with my partner.	
Everyone wants something from me at the same time.	
I have many unfinished tasks to do.	
My own situation: _____ _____	

Scale: 0 = does not stress me out at all; 1 = stresses me out a little bit; 2 = moderately stresses me out; 3 = really stresses me out; 4 = completely stresses me out

Which stressful thoughts do I recognize?	I think them from (0) "never" to (4) "always"
I can't do this.	
It's all too much for me.	
It's always me…	
I'm completely lost.	
I can't stand it anymore.	
They want to finish me off.	
I have to please everybody.	
My own thought: _____ _____	

Scale: 0 = I never think this; 1 = I seldom think this; 2 = I sometimes think this; 3 = I often think this; 4 = I always think this

Which reactions to stress do I recognize? (please underline and add your own)	I experience these from (0) "never" to (4) "always"
Physical: muscle tension, heart racing, trembling, restlessness, pain, nausea.	
Emotional: anger, fear, powerlessness, helplessness, disappointment.	
Behavior: running away, hitting someone, dissociating, hurting myself, retreating, insulting or yelling at someone, screaming, smoking.	
My own reaction: _____ _____	

Scale: 0 = never; 1 = seldom; 2 = sometimes; 3 = often; 4 = always

| Describe a stressful situation with your child: |
| --- |
| What was the cause of the stress? |
| What stressful thoughts did I have? |
| How did I behave? |
| What were the immediate consequences? |
| How do I now evaluate my behavior in this situation? |

Case study

Jenny had now learned that excessive stress is unhealthy for her child. She now often criticized herself because she was constantly stressed, but had no idea how to change her situation. She used to smoke pot, yell, or harm herself. This had given her some relief—only for a moment, but at least it was something! Now she was faced with having to change how she coped with stress, but was at a complete loss about how to proceed.
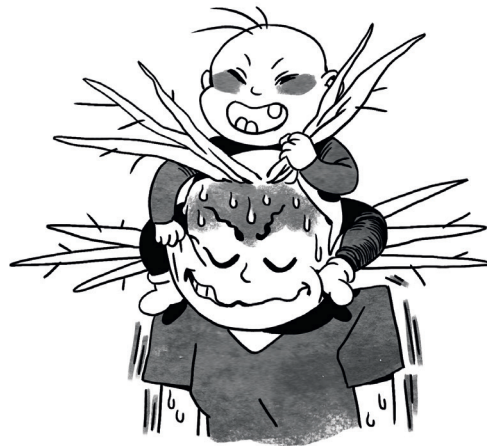
Although we often have little control over our reactions to stress, we can do a lot to curb harmful behavior and find more composure in the long term.

Planning

One way to address stress-triggering situations and factors is by planning ahead. We can plan for situations that we already know are stressful for us, or even avoid them if possible. We could, for instance, set our alarm clocks a half hour earlier in order to have more time to prepare ourselves and our children for the day.

Increasing stress tolerance

We can work to increase our stress tolerance in the long term, e.g. through:

- ► Mindfulness and relaxation: stopping to reflect, taking a step back, taking a deep breath, taking small breaks.
- ► Changing our attitudes to mistakes: conflicts and mistakes are a part of life; if I stay calm, I can take control of the situation.
- ► Increasing acceptance: tell yourself things like "stress happens"; "it is what it is, and I can't change anything now".
- ► Self-care: regularly doing activities to find some balance (e.g. yoga, meditation, and relaxation exercises).
- ► Healthy living: eating regularly, sleeping sufficiently, paying attention to our health, exercising regularly.
- ► Problem-solving strategies: do what is effective; negotiate compromises rather than hitting our heads against the wall.

Pause
Stop! I'm about to do something that I might regret. Pause and reflect for a moment, take a deep breath, take a "time-out" (e.g. leave the room for a moment, get help if necessary).

↓

Breathe
Take a few conscious breaths.

↓

Accept
The situation is hard to bear and I don't know what to do anymore—but that's how it is. When I hit my head against the wall, scream at my child, or harm myself, it only makes the situation worse. It's not about solving my problems right now, but about withstanding the next fifteen minutes.

Distract
Do something that has nothing to do with the situation in order to calm myself down (look out the window and describe what I see; perform a routine like clearing the table, making tea).

Get active
Try out alternative behaviors (e.g. approach my child in a different way or with a new idea: sing a song, look at a book).
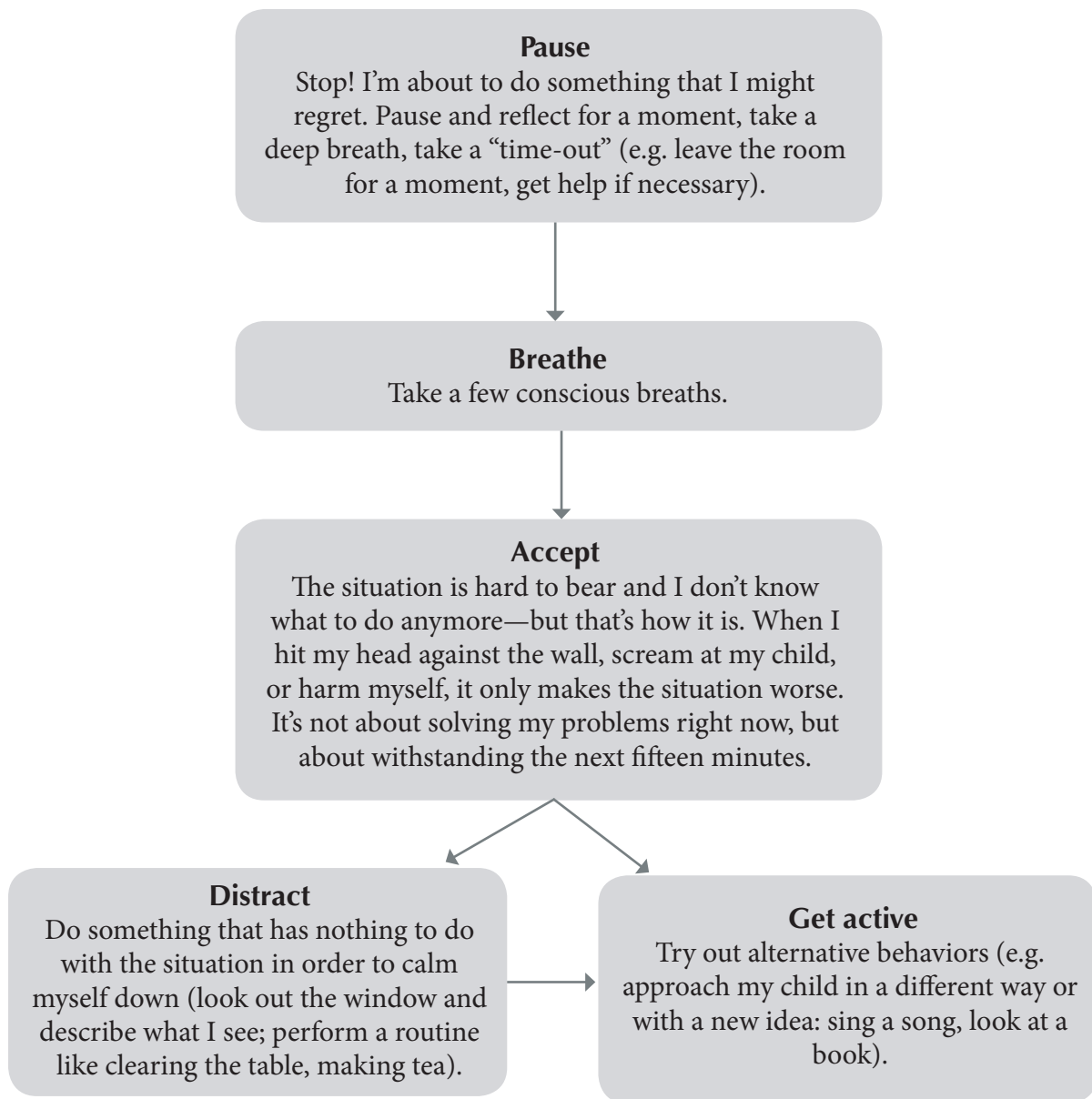
Figure 3: "Pause, breathe, accept, distract, get active"

Example

Sometimes it feels as if I am driving a car around the same narrow bend again and again, and is surprised every time when I lose control and lands in a ditch. I can practice driving around the bend, drive slowly, or find another route. But I must realize: this is a danger point, and it will not dissolve into thin air if I ignore it or step on the gas pedal to get it quickly behind me.

Transferred to everyday life, this means that you should learn from your own experiences and rethink your own behavior rather than continuing to do what has not worked in the past. Situations with your child will always arise in which "nothing works"—and then what? In this case, the "Pause, Breathe, Accept, Distract, Get Active" strategy (see H 5 Figure 2) is recommended.

If reflection does not work so well for you in stressful situations, it is advisable to have some alternative tried and tested strategies at hand. The "Tool Kit" (HS 5c) is intended for this purpose.

"Acquiring Skills" (HS 5b) gives examples of strategies that have proved successful for some mothers and their children.

Quiz question: What are the five steps in the stress management strategy?

Over one week, observe any new methods of stress management you try, and write them down as soon as possible.

How did you try to influence stressful situations in advance?

What did you do to keep from damaging your child in this situation?

How successful would you say your behavior was in this situation, as compared to your usual behavior?

Attention: Some of these skills are only for emergencies when your stress level is over 70. They should not be used regularly!

General strategies

▶ Sit down, take a moment, and breathe. Tell yourself: "If I don't know what to do now, I won't do anything until something comes to mind."
▶ Consciously inhale and exhale.
▶ Count backwards from 10 to 1.
▶ Pant, growl, snort, grimace, roll your eyes.
▶ Briefly leave the room and calm down (note: only do this if the child is safe; otherwise make sure that the child is safe first).
▶ Leave the situation with your child.
▶ Help yourself calm down with strong sensory stimuli: smell chili peppers or ammonia (be careful with this around children!), hold an ice pack, put your head under cold water, listen to loud music (with headphones), squeeze a stress ball, snap rubber bands, eat strong candy, chew gum.
▶ Drink cold water.
▶ Move: do squats, push-ups, use a Thera band, lift dumbbells.
▶ Read a book or a sheet that suggests helpful thoughts and ideas (prepare this beforehand!) e.g. "I'm doing my best. I can do this."
▶ Read a list of pros and cons of impulsive behavior (prepare this beforehand!).
▶ Call someone.

For crying babies (when they are crying and you have checked for all possible causes such as hunger, thirst, a full diaper, etc.)

▶ Tell yourself: "This will pass—it's normal for babies to cry."
▶ Use earplugs or listen to your favorite music with headphones while you hold the baby in your arms and try to soothe her.
▶ Move the baby in your arms (dance, sit on an exercise ball, bounce, squat, rock the baby).
▶ Have a curious attitude: look closely at the child and take note of exactly how she cries, as if you were describing her to a Martian.
▶ Take the child for a walk (in a stroller or a sling).
▶ Play soothing music.

For older children

▶ Distract yourself together with your child (play, draw, sing, cook, bathe, go for a walk).
▶ To give yourself some room to respond effectively to your stress, postpone appointments, take your time, etc.
▶ Tell yourself: "This will pass—it's normal, and good, for children to have a will of their own."
▶ Take a short time-out from the child (go into another room).

Stress tolerance for children

Like adults, children who are in a state of high tension and anxiety can no longer think clearly or act sensibly. Trying to discuss the situation with them or demand that they act reasonably often only makes the situation worse. So what can a mother do when she is feeling somewhat

calm, but her child is completely out of touch with her?

The following options are available:

► Make clear decisions and act in the child's favor (e.g. leave the situation with the child).
► Reduce external stimuli (e.g. bring the child into a quiet room, turn off the TV, turn off the light).
► Give the child external stimulation through physical contact, a cold towel, a hot-water bottle, a stuffed animal, a pacifier; try it out and see how the child reacts! Avoid candy whenever possible!
► Distract the child by showing her something, playing with her, singing, telling her a story; avoid TV and computers whenever possible!
► Surprise the child, e.g. by behaving like a child yourself or doing something unexpected.
► For older children who often "flip out", use the Tool Kit you had prepared together beforehand.

When the child has calmed down, it is important to return to the original situation, so as not to reward the child's crisis behavior.

How I can reduce my tension when I am in a crisis situation

through distraction	
through thoughts	
with my five senses	
by changing the situation	
through moving and body posture	
through breathing, mindfulness, and the "Pause, breathe, accept, distract, get active" strategy	
hrough other methods	

Case study

Again and again, Jenny intended to put Robin to bed at 8 o' clock on the dot. She wanted to finally have time for herself to watch her favorite TV show. She left Robin no room to add to the routine: it was book reading! Tooth brushing! Bed!

But Robin always thwarted her plans by getting out of bed and coming to her wanting something. Jenny would regularly lose patience, shout at him, and sometimes gave him a slap. After that, she was such a nervous wreck that she did not care about anything. She shut her door and left Robin to himself.

We have to make many decisions every day: What do I wear? What do I eat? What do I buy? How do I spend my time? When do I go to bed? What do I allow or forbid my child to do? Do I stay with my partner, or should we separate? On the one hand, this means we have a great deal of freedom to make decisions; on the other, the stress of decisions can lead us to feel uncertain and overwhelmed.

Children need a clear and predictable daily routine with sensible rules, habits, and rituals. They learn from consequences, experiences, and above all from the reactions of their caregivers, upon whom they want to rely. However, if a child's caregiver always reacts differently to the same situations, the child becomes confused and uncertain in the long term.

How parents can deal with children

As a parent, it is often not easy to decide how lenient or strict to be.

Too lenient. Any adult who always submits to the whim of their child is not doing their child any favors: the child becomes the "boss", but is also easily overwhelmed because he cannot see the consequences of his actions.

Too strict. Very strict and rigid rules may help a child "function" in the world, but they cause important needs to fall by the wayside. Children who are subjected to such rigid rules have difficulty becoming self-reliant and self-confident enough to make their own decisions.

Frequent shifts in behavior. Frequent shifts from extreme leniency to excessive strictness are especially difficult for the child because they are not comprehensible. A child does not know where he stands, and that can lead to stress in the form of fear, panic, helplessness, abnormal behavior, or withdraw. Children particularly depend on a structure that provides them with security, but that structure must be also flexible.

Example

It is bedtime, and the child still wants to play. Depending on her mood, the mother either scolds her child (when she is annoyed), or she gives in and plays with her child (or both). Maybe she feels guilty because she has not attended to her child very much today, and does not want to refuse him anything. Maybe she does not want to be bothered by her child and tries instead to dispute, hoping he might see that he has to sleep. The consequence is: there is a permanent fight over going to sleep.

Sensible rules

It is useful for a mother and child to have a pleasant bedtime ritual (e.g. singing a song, reading aloud) that helps the child make the transition to sleep. This ritual should be performed the same way every evening. A child will remember a ritual like this for the rest of his life, and associate it with good memories and a feeling of security.

As well as providing good structure, sensible rules and habits should help to simplify everyday life, relieve it of doubts, decision-making problems, and conflicts, and make it more enjoyable for mother and child to spend time together. The easiest way for children to learn rules is by watching their parents as role models (being friendly with each other, washing their hands before eating, keeping tidy, letting others speak, listening, avoiding violence, etc.).

Other rules and prohibitions are intended to keep the child safe (holding the child's hand while crossing the street). Prohibitions should be used sparingly, so as not to lose their potency. If a child continuously hears "no", he will not react to it properly in case of emergency. A system of structure and rules works when both the mother and her child can relax, as well as meet their responsibilities, and pursue their goals.

Example

The mother and her child always get up at the last minute. They do not have any time to have a relaxed breakfast—they have to be quick about everything. The child is stubborn, the mother annoyed. The short-term advantage is that they get to stay in bed for longer, but they are constantly running late, causing the child's kindergarten and the mother's workplace to get annoyed.

Sensible solution. The mother gets up half an hour earlier. Even if this is hard to do and means less sleep in the short term, the mother is able to get dressed and eat breakfast in a relaxed atmosphere, and this causes less anger.

Rules must be comprehensible

At the beginning, it is generally difficult to introduce a system of rules and rituals. It takes planning, discipline and tenacity; but it is worth it if it makes life easier and more pleasant. It is important to explain to a child why a new rule is being introduced: e.g. to point out at bedtime, that it is nicer to go to bed without crying, screaming, or feeling angry. Thus, the child understands why a rule is introduced, and by formulating the reasons, the mother is able to understand herself better and stick to the rule. It can also be helpful to write down the new plan. A newly introduced rule should always be checked and adjusted as necessary.

Quiz question: Name two (or more) areas in which a young child needs fixed rules.

Record a typical daily routine with your child. Rate how satisfied you typically are with each individual activity.
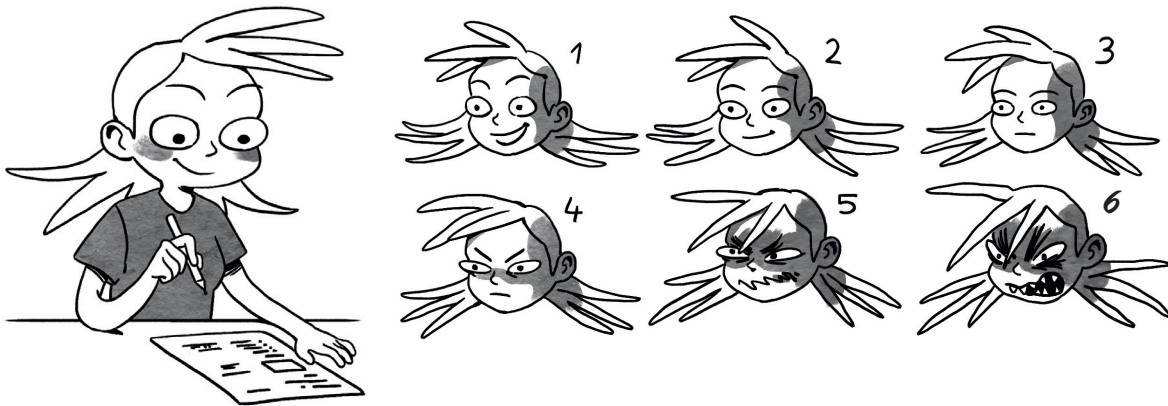
Time of day	Activity	Rating from 1-6
Early morning		
Mid-morning		
Noon		
Afternoon		
Evening		
Night		

Scale: 1 = very good; 2 = good; 3 = satisfactory; 4 = sufficient; 5 = poor; 6 = inadequate

Examine a typical daily routine from the perspective of your child: What was good? What bothered your child? What else could the child have needed? How satisfied was the child?
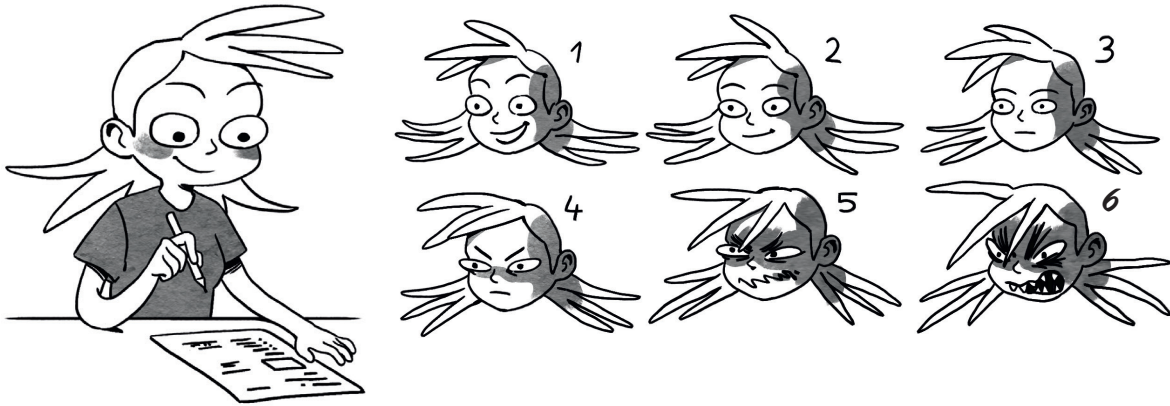
Time of day	From the child's perspective: What is going on? How did the child experience it?	Rating from the child's perspective from 1-6
Early morning		
Mid-morning		
Noon		
Afternoon		
Evening		
Night		

Scale: 1 = very good; 2 = good; 3 = satisfactory; 4 = sufficient; 5 = poor; 6 = inadequate

Review your daily routine once more and answer the following questions:

(1) What is going well and can stay as it is?

(2) Where do you always run into problems?

(3) Try to distinguish between what you can and cannot influence:

Able to be influenced	Unable to be influenced

(4) How can you make life easier for you and your child?

Case study

Robin was now almost two, and he was pretty exhausting for Jenny. The main problem was that he just didn't listen. Jenny had tried everything to get him to clean up his toys, get dressed, or brush his teeth, but for better or for worse it always ended in chaos. Either she finally gave into him and got annoyed about it, or she pushed through until she was a total nervous wreck. She often did not know what else to do. She did not want to hurt him, but when she was too nice to him, he walked all over her. She felt guilty when she got angry and scolded him. No matter what she did, it was not right.

Conflicts are normal

Conflicts are a part of normal development, and are mostly connected to the fact that children and parents do not fulfill one another's expectations. Many conflicts derive from misunderstandings and a lack of knowledge. Mothers may repeatedly experience that their children don't behave as they would wish for, that they do something the mother doesn't like, that they don't do what they have been told again and again. And when a mother asks her child "Why are you doing this…?" she often is not answered, but rather ignored, provoked, insulted, or even hit.

Why do children behave like this?

There are several reasons:
► because this behavior gets them what they want or need
► because something did not go the way they wanted it to and they want to express their dissatisfaction
► because they see no other way of attracting attention
► because they imitate what we demonstrate to them
► because they want to know if we really mean what we say.

The previous module was about rules and structure. The clearer and more reasonable these are, the more anger and resentment can be avoided. Nevertheless, conflicts will always arise—the child will inevitably want something different than the adult. This is normal. There are situations in which the child should decide for herself, situations in which the adult should assert herself, and situations in which a compromise should be reached. As much as possible, it should be clear who determines what and when, though opinions on what and how much a child should get to determine for herself still vary.

Who determines (what)?

The child should determine:
► whether she plays
► how much she wants to eat
► how or to whom she wants to show affection.

The adult caregiver should determine:
► whenever reasonable rules should be followed (e.g. bedtime, screen time, teeth-brushing, tidying the bedroom)
► whenever the child is harming herself or others with her behavior (e.g. by behaving aggressively, eating too much candy, wearing inappropriate clothing)
► whether important issues take precedence over the child's needs (e.g. appointments, the adult's own interests).

The adult should give in or find a compromise:
► when what it wants from the child is not age-appropriate or otherwise violates the child's needs or dignity (e.g. leaving the child alone, forcing the child to do non-child-friendly activities, forcing physical contact on the child, such as giving her a kiss)
► if the child's behavior is not dangerous and the rules are not clear (e.g. if the child empties out a drawer of Tupperware)
► if there is no important or objective reason for the adult to assert her will (e.g. if the child wants to put on red pants rather than blue)
► if there is a good compromise (e.g. using negotiation tactics, such as staying behind for fifteen more minutes rather than leaving immediately).

Diffusing and managing conflicts
There are several useful behavioral options for solving and managing conflicts with children:
► staying calm (and using stress tolerance skills beforehand)
► getting to the child's eye level to make sure you have her attention
► naming the child's adverse behavior ("I don't want you to hurt me. Please stop right now.")
► giving advance notice ("I want to leave in 10 minutes"), and possibly negotiating a compromise to get the child to agree
► giving clear, concrete, and age-appropriate instructions ("I want to leave now. Please put your jacket on.")
► when it is possible and reasonable, responding to the wishes and needs of the child and negotiating a compromise
► if the child does not react, repeating the request, announcing the natural and appropriate consequences of the child's actions (e.g. "I just told you to put your jacket on and you're still playing. I want you to come right away—otherwise, we'll miss the bus and we'll have to walk").
► when necessary, carrying the child—keep calm and take care not to hurt her
► acting in a consistent way.

What should be avoided?
Physical violence and roughness (arm-pulling, pushing, causing physical pain) should always be avoided. So should uncontrollably yelling at the child, harshly scolding or humiliating her ("You're wicked—I can't believe I have a child like you!"). Threats and negative predictions (e.g. "Just wait until your father comes home!", "If you keep acting like this, no one will like you"), humiliation and irony (e.g. "Well congratulations, you've done everything right again"), and laughing at the child are not helpful in resolving a conflict.

Quiz question: Is there always a 100% correct way to deal with conflicts with children? Is there a single solution that will work in every situation?

Rate how difficult (stressful) each situation would be for you, and how you would most likely react to it.

Situation	Stress (from 1-5)	Your reaction
You are standing with your son by the cash register at the supermarket. He really wants a candy bar. When you tell him "no," he reacts angrily, whining, "but I want it!" A queue is forming behind.		
You have just put your daughter to bed; you are tired, and want to watch your favorite TV show. But your daughter keeps coming out of her bedroom and wants something to drink.		
A friend of yours with children is having you and your daughter over. You want to go home, but your daughter does not want to leave yet.		
Your daughter wants an ice cream. You tell her no, but your partner tells her yes.		
Your son refuses to brush his teeth.		

Scale: 1 = very easy; 2 = easy; 3 = average; 4 = stressful; 5 = very stressful

Situation	Stress (from 1-5)	Your reaction
Your daughter is playing with her food instead of eating it.		
You have taken the TV remote away from your son. He tells you, "you're the stupidest mom in the world."		
Your baby will not stop crying, even though she has eaten, she has a clean diaper on, and she needs to sleep.		
Other/own situation:		

Scale: 1 = very easy; 2 = easy; 3 = average; 4 = stressful; 5 = very stressful

Describe a typical conflict with your child: What is it about, and what do you expect?

_____

_____

_____

_____

Strategy	Which strategies do you use, and how frequently? (1-6)	What sort of behavior does your child exhibit, and how frequently? (1-6)
explaining		
scolding		
yelling		
hitting		
threatening		
ignoring		
negotiating (offering a compromise)		
begging		
warning the child about the consequences of her actions		
consoling		
giving in		
persisting		
other:		

Scale: 1 = never; 2 = seldom; 3 = sometimes; 4 = frequently; 5 = very frequently; 6 = always

How do you deal with conflicts?

_____

_____

_____

What should stay as it is and what would you like to change?

_____

_____

_____

Case study

Jenny had learned to keep her feelings to herself as a child: when she was sad, no one cared. When she was afraid, she was not supposed to make a fuss about it. When she was angry, she was hit or sent to bed without dinner. She had learned that it was best not to show or pay attention to her feelings. Only when a feeling was so strong that she could not ignore it would she react— usually very intensely and frantically.

When Robin cried or got angry, Jenny quickly got annoyed and wanted him to stop. She thought—and often told him—that he had no reason to be angry or cry, and he should not make such a fuss. Most of the time it did not help, but she did not know what else to do. She repeatedly was getting annoyed by her son's emotional outbursts.

Children's and adults' emotions

A person's emotional landscape is initially comparable to an undiscovered planet. He/she does not yet separate feelings, needs, and physical sensations, and they are perceived as "pleasure - pain" or "hunger - satiation". The first evaluations are "pleasant - unpleasant".

Over the course of our lives, we develop preferences for certain emotions and avoid others that we find unpleasant or frightening. Consequently, we become better acquainted with some feelings, while others we hardly recognize at all. Maybe we grew up in a rough area, are now familiar with it, and do not want to leave it for fear of the unknown, even if we often dream of getting out.

It is helpful for adults to be familiar with their own emotional landscapes if they want to look after their children's emotional development. Otherwise, they may have trouble helping their children through difficult emotional states–if they have no experience with sadness, for instance, they will be helpless in the face of their children's sadness. They may even end up teaching their children that certain emotions are bad, and one should not have them (e.g. "That's no reason to cry"), even though every emotion has an important meaning.

Helpful attitudes

Helpful attitudes in dealing with your child's and your own emotions are:
► All feelings have a meaning.
► All feelings pass.
► Feelings are not the same as behavior: All feelings are permissible, but not all associated behaviors are.

Emotions and needs

The following is an overview of emotions that are particularly important to a parent-child relationship, and can serve as signposts:

Anger and irritation. Anger develops when one's important goals or needs are threatened. Anger is an important feeling that serves to defend one's own interests. When someone is intensely angry, she feels the urge to attack—either physically or verbally—in order to look out for herself. The body is also involved in this fight. Infants cannot yet experience anger, but they

can experience discomfort and pain. During the course of a child's second year, when he is increasingly able to have control over his environment, he starts to more frequently experience anger. This anger exhibits itself most clearly during the "defiance phase", sometimes called the "terrible twos". After the second year, the frequency of angry outbursts usually decreases over the pre-school period (Lohaus et al., 2010).

When a child is angry, he needs a counterpart who is simultaneously stern and understanding, and who gives him support and, if necessary, gives him boundaries without hurting him.

Fear. Fear is the body's way of preparing itself for danger. Experiencing fear is part of healthy human development, though the things of which one is afraid vary greatly during the course of life. In the first year, fear of separation is in the foreground, and is expressed by the fact that babies turn to their mothers for protection and not, for example, to strangers. In toddlerhood, further fears arise. These include, for example, darkness, and unfamiliar animals, people and situations. With increasing development of language and imagination, the child might also fear ghosts, witches, monsters, war, death, "bad people", burglars or social exclusion.

A fearful child needs support and encouragement.

Sadness. Sadness is a reaction to loss. When someone is sad, she cries, retreats, or seeks closeness to others. By crying, a child signals: "Right now I need someone to be with me."

A sad child needs comfort and support.

Joy. Joy is a positive feeling of agreement and harmony with the world. It often results from a child's small and large successes and discoveries (e.g. that you can paint really well on wallpaper!).

Children who are joyful want to share that joy, though sometimes children also need to experience that their joy is not always shared.

Love. Love is a feeling of deep attachment to another person. Young children especially have no choice but to love their parents, because they are existentially connected to and dependent on them. They love their parents the way they are, unconditionally.

If a child feels unloved, he looks for ways to at least find a substitute for love (attention, toys, candy). Many of the child's other feelings can be a result of unrequited love, such as anger, fear, grief, jealously, guilt, and shame.

Children need to see and be allowed to show signs of affection and love.

Shame. A child develops shame by violating personal or social norms. Children develop shame only when they are aware that they have violated a norm (e.g. when they are caught stealing). Shame also occurs when a child fears exclusion from his community: that the community might judge some unalterable part of the child's character as inferior or bad. The child then tries to make himself small, so as not to be seen or attract unpleasant attention.

Children who feel ashamed need compassion, acceptance, encouragement, and respect.

Guilt. A child develops guilt when he gets the impression that he has done something for which he deserves to be punished. Although children often do not understand what they did wrong or what they could have done differently, guilt—unlike shame—contains the hope that everything will be fine if only the child makes enough effort or changes.

When a mother constantly tells her child that she is unhappy with him, the child tends to believe that everything is his own fault rather than understanding that his mother is impossible to permanently satisfy. Children often feel guilty and responsible for things for which they are not responsible. It is therefore often easier for a child to bear the guilt rather than to recognize that he may be "innocent" and at the mercy of the whims of his caregiver.

A child who feels guilty needs a caregiver who takes responsibility for her own behavior and apologizes for her own mistakes. This way, the child can learn to admit and apologize for his

own mistakes.

Disgust. Disgust is a sensation of strong repulsion associated with nausea and vomiting, and which is supposed to protect us from, for example, poisonous food, or from people who appear unpleasant or threatening. While the ability to feel disgust is innate, what we find disgusting is learned. While small children indiscriminately put everything—from earthworms to their own feces—into their mouths, they develop disgust over time from experience and examples. Around the age of three, children start to show clear reactions of disgust, e.g. to unknown food, smells, or closeness to unknown people. Children who feel disgusted (e.g. by food they do not recognize) need patience and role models, and should never be forced to do anything that disgusts them.

Helplessness/Powerlessness. A person starts to feel helpless when she sees no ways in which she can influence a given event. Children also experience helplessness and powerlessness, especially when they cannot assess a situation, and do not know if it is dangerous or what will happen next. Anyone who feels helpless or powerless will also feel angry or afraid.

Children who feel helpless and powerless need support and protection as well as a sense of security.

Emotions and stress

It is often not easy to deal with your child's and your own feelings in stressful situations. First, you should check your own tension. When your tension level is above 70 (the point at which a person loses control), it is best to use stress tolerance skills (HS 5c) until the tension diminishes. When your tension is lower and you have a better hold of yourself, it is important to identify your own feelings. It is healthy and completely normal for the child's expression of emotions to trigger emotions in the adult. If babies cry for a particularly long time, this often triggers anger and helplessness in their parents. The fact that babies cry is a fact of nature—they cannot do anything else, and crying activates adults to help them. Babies who are left alone or often shouted at may give up at some point, become apathetic, and can develop severe disturbances in the long run. This is why it is particularly important for parents to be able to calm themselves down in such situations. To do this, it is first necessary to identify your own feelings. Ask the question: What do I feel physically? What's going on in my head? What would I want to do if I could do what I liked? What do I need right now?

> **Example**
>
> I am on my way home with my three-year-old, carrying heavy grocery bags in both arms. It is a rainy day; I am cold and exhausted, and want to go home. My daughter has just discovered her enthusiasm for puddles and stops in the sidewalk all the time. I am annoyed. But instead of saying "You are so draining, stop trying to annoy me", I could change her attitude: "I'm sorry, but I'm cold, I'm carrying heavy bags, and I want to get home quickly. Could you please come with me?"

What you should do	What you should not do
Observe the emotion; do not evaluate it (in a quiet tone, ask, "What's happening?").	Order, forbid, or talk the child out of the emotion ("Be happy; stop being annoyed; you're not really afraid").
React to the child ("Are you sad?").	Ignore the child with hostility (act as if the child is not there instead of honestly telling him what is going on).
Validate the emotion; take it seriously ("Yes, that's a pity/sad/stupid").	Laugh at or ridicule the child ("You crybaby!").
Endure the fact that the child is just sad or angry, just be there for him, say nothing, and look friendly.	Use sarcasm or irony ("Oh great, you've had a tantrum!").
Stick to the situation ("I don't like that you're doing … right now").	Use the word "always" ("You're always…").
Offer support and encouragement ("You can do it. I'll help you.").	Trivialize the emotion ("Don't make such a fuss.").
Speak from the "I" perspective (I'm annoyed by your behavior").	Speak from the "you" perspective ("You're making me angry/sad").
Limit certain inappropriate behavior, e.g. screaming, throwing fits, endless yelling ("That's enough").	Allow all behavior associated with the feeling.

Finding a balance

The child's feelings often do not "fit in" with those of the adult, and vice versa. But what to do when the adult and the child's feelings do not match?

It is not essential for a child's development to share every feeling, but it is crucial that the child is allowed to have his own feelings – same as the mother. Even when we cannot understand the reasons for a child's joy, anger, or sadness and do not have to act accordingly, we know how it feels to be excited, sad or angry ourselves. We comprehend these feelings, and know that they cannot be turned off at the push of a button.

Dealing with the child's emotions

The following are some examples of how to—and how not to—deal with a child's expressions of emotion.

Quiz question: Does accepting your child's feelings mean allowing him to do whatever he wants?

Imagine that your child is flailing around, screaming, and insulting you: "You're such a stupid mama!"
Which feelings could a mother have in this situation? What would she most like to do (behavioral impulse)? Look at the previous list of feelings (see H 8) if you need help, and write a line about each feeling in the table.

Your feeling	Behavioral impulse

Which feelings might be the cause of the child's behavior? What does my child need? How can I behave appropriately as a mother?

The child's feeling	The child's need	Appropriate behavior for the mother

Observe and describe a situation in which your child showed its emotions.

Trigger event:	
What thoughts did I have?	What was my child probably thinking?
What did I most want to do?	How did my child behave?
What feelings did I have?	What feelings did my child express?
What did I do?	
How did my child react?	
What happened then?	

Case study

Most of the time Jenny found it difficult to feel at all. When Robin was 18 months old, he often came to her wanting to cuddle. It was too much for her—often she could not bear his need for closeness. Still, she had learned that children need a sense of physical security, so she let him climb on her lap, albeit tensely and reluctantly, and turned her head away. Robin would then start to squirm and whine, though Jenny could not understand why. She would scold him: "Now you have what you want! Stop fidgeting and tell me what you need!"

The body from the child's perspective

Babies. Babies do not yet have any language and are limited in their ability to move. They use their bodies and vocal signals to tell us how they are doing. Is the baby turning away and whining? Or is she reaching out and laughing? We can never be completely sure of what a baby really wants to tell us, but we can observe and learn to understand her body language. At the same time, a baby learns from our reactions, as if she were thinking: "Just now I laughed and said 'gaga', and mom looked happy and took me in her arms. That felt good."

Toddlers. Especially when children are not yet able to speak very well, they perceive what their mothers want to say to them from bodily, facial, and vocal signals. They have very sensitive antennae for their caregiver's moods, and often perceive very accurately: Is she relaxed or stressed? Is she holding me securely or insecurely? Is she touching me lovingly, with hostility, or like I am an object?

Older children. Older children are able to communicate with words, but when in doubt they still rely on body language. If a mother says: "I love you," but pushes the child away or uses an irritated tone, the child will not believe she is really loved, but will rather feel confused, sensing something is wrong.

What adults express with their bodies

Conflicts. Objectively speaking, adults are much bigger and stronger than children, but they often use too much or too little of their strength during conflicts with children, or avoid physical contact with the child entirely.

► **Too much physical force:** hurting the child, treating her like an enemy, violating her personal space, shouting at her, threatening her, tugging at her, pushing her, hitting her, handling her roughly.
► **Too little physical force:** letting the child hit you or mistreat you, behaving helplessly, submitting to the child, setting no boundaries for the child.
► **Avoiding physical contact:** leaving the child alone, walking away, ignoring the child.

A child cannot understand why a stronger adult is fighting with or submitting to her. She may think she is mean, or she may feel alone and helpless. She does not get a good sense of her own body and strength, and her physical integrity is unsupported.

When an adult uses an appropriate amount of strength, she wordlessly tells the child: "I am big and strong and will use my strength to care for and protect you. At the same time, I do not allow you to overstep my boundaries and hurt me, because I want you to learn how to deal peacefully with me and others." The child then feels safe and protected, and gets a realistic understanding of her own physical boundaries and possibilities.

Feelings and affection. Affection too is mostly conveyed nonverbally: loving touches, smiles, and a friendly voice convey security, protection, and safety. Even small touches and gestures can make a child feel accepted and valued - an important basis for the child's further development (see Module 3, "The Basic Needs of Children). It is important to pay attention to how your way of using your body affects your child—that is, whether your child wants physical affection at the moment.

Facial, vocal, and physical consistency

How would you feel if a relaxed and smiling person told you in a low voice, "I am so mad at you"? Or vice versa: if he said "I love you" in a rough voice, with clenched fists and a grim expression?

It is very confusing for a child when what we say does not match our body language. The child does not know what to believe, and starts to mistrust her own feelings. In order to learn how to regulate her emotions, a child needs confidence to confirm that her feelings are real. Parents can support their children by expressing themselves respectfully, credibly and clearly, so that

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The "Physical expressions skill"

The "Physical expressions skill" can help you bring your physical expressions in accordance with what you wish to say to your child. Your stress level should be below 70 when using this skill—if it is not, you should use stress tolerance skills beforehand.

► Be aware of your posture and facial expressions (e.g. look in the mirror).
► Check and be aware of your breathing and stress level.
► Let go and smile gently.
► Think - What do I want to say to my child? What do I want to express?
► Agreement - does my expression match what I want to say?
► Bond and establish closeness with the child.

Quiz question: Does a child listen more to what you say, or how you say it?

Choose two situations with your child in which you are aware of your own body language. Observe your own and your child's body language, respectively.

1. Observe your own body while you speak to your child. What did you notice about yourself?

	In a conflict situation	**In a harmonious situation**
facial expression (e.g. stern, frowning, smiling?)		
gestures (e.g. arms reaching out, or hands on hips?)		
posture (e.g. facing the child or turned away?)		
breathing (hasty, strained, calm, deep?)		
physical tension (e.g. high or low?)		
_____ _____		

2. Observe your child's body. What did you notice about your child?

	In a conflict situation	**In a harmonious situation**
facial expressions		
gestures		
posture		
breathing		
physical tension		
_____ _____		

Case study

Jenny had a fairly clear idea of how to be a good mother, and did her best to live up to it. She did not want to leave anything lacking in Robin's life as her own mother had done for her. She wanted for him to never have to feel as lonely and deserted as she had. For instance, she did not want him to cry alone in his bed, so she spent a large amount of time every night sitting at the bedside of the restless child, vacillating between attempts at calming him and frustrated outbursts, until he finally fell asleep. Afterwards she thought, "What sort of terrible mother am I, that I can't even calm my own child down?"

What are basic assumptions?

Every person develops certain basic assumptions, about herself and other people, based on her experience. These basic assumptions or attitudes are often taken as the absolute truth.

Examples. Examples of basic assumptions are:

► "I am a failure!"
► "My partner will leave me sooner or later anyway."
► "I cannot assert myself with my child."
► "I am a good mother. I will cope with whatever difficulties arise."

The more we believe in these thoughts, the more we act on them, and in most cases, the more our actions then confirm these assumptions. Even if, contrary to expectations, something else—good or bad—happens, we find an explanation for it that fits our basic assumptions.

How do basic assumptions work?

Basic assumptions are learned early on, provide direction in life, and allow us to predict how to face relationships and life tasks. They also protect us from unpleasant surprises and disappointments, and help us to more sensibly use our own abilities. For example, if I assume I will always be a failure, I will not have to put any effort into what I do anymore. Or if I assume nobody likes me, I don't need to try to make friends. But here's the catch: How do I know that I will always fail in the future, just because I have in the past?

Unfortunately, overly rigid basic assumptions do not allow us to adapt to our living conditions when they change. Such basic assumptions are like outdated laws—they were valid at one point, but are now obsolete. They still continue to affect our lives as we follow them, but this does not prove their validity.

Societal attitudes toward parenting

There are many different attitudes on how to raise a child. While many assumptions about parenting—such as "beating a child is harmful to its development"—are now taken for granted in our culture, they were seen quite differently in the past. There are many reasons for this shift: for one, our attitude towards physical violence and authority has completely changed.

The state no longer delivers corporal punishment to adults, and the belief that children should obey unconditionally has gone out of fashion—instead, we expect children to behave with self-awareness. Such a shift in attitudes also, of course, affects parenting.

Hindering basic assumptions in parenting

There are certain, almost automatic ideas that arise when something happens that one cannot explain: for instance, the child keeps crying, even though he has been fed, had his diaper changed, and had sufficient sleep. The mother is frustrated, and thinks: "My child is only doing this because he wants to annoy me."

These beliefs affect how we react to our children, so it is important to recognize them. Recognizing the beliefs is the first step towards achieving some distance from them. The second step requires us to examine our beliefs, and to admit that, even if they are understandable, they are not helpful in coping with difficult situations with our children. This is especially important because our children adopt many of our basic assumptions, which can then have a major impact on their lives. Many assumptions are passed down from generation to generation until someone breaks the cycle.

Recognizing and dealing with basic assumptions

You can recognize basic assumptions (beliefs) because they are self-justifying ("Why can't I do this? Because I'm a failure", "Why can't I show any weakness? Because I have to be perfect"). They cannot stand up to objective reality checks. Harmful beliefs prevent us from developing and reaching our goals.

> **Helpful questions**
> Helpful questions to test a basic assumption are:
> ► Is this thought helpful?
> ► Is this thought extreme?
> ► Would my friends also see it this way?
> ► Is this a belief, or a fact? Would others describe it as a fact?

Quiz question: What questions can you use to check whether a basic assumption is helpful?

Check off the statements with which you particularly agree. What are your "Top Five"?

Hindering assumptions
☐ I can only be a good mother if I put my child's needs before my own.
☐ If my child is crying and I cannot calm him down, that means I am a bad mother.
☐ If my child is mean to me, it means he cannot stand me.
☐ My child feels exactly what I feel (preferences, aversions, temperature, hunger).
☐ I cannot bear it when my child is angry or sad.
☐ I am only allowed to feel good if my child is feeling good.
☐ If I have done everything for my child and he is still crying, that means my child wants to annoy me.
☐ If I say "no" to my child, my child won't be able to stand it.
☐ Saying "no" to my child endangers our relationship.
☐ I only have two options: let my child tyrannize me, or use corporal punishment.
☐ If I do not miss my child, I am a bad mother.
☐ If I occasionally do not have fun playing with my child, I am a bad mother.

How could you reformulate your ""Top Five" assumptions in a more helpful way?

1 ._____

2. _____

3. _____

4. _____

5. _____

Case study

Jenny had a fairly clear idea of how to be a good mother, and did her best to live up to it. She did not want to leave anything lacking in Robin's life as her own mother had done for her. She wanted for him to never have to feel as lonely and deserted as she had. For instance, she did not want him to cry alone in his bed, so she spent a large amount of time every night sitting at the bedside of the restless child, vacillating between attempts at calming him and frustrated outbursts, until he finally fell asleep. Afterwards she thought, "What sort of terrible mother am I, that I can't even calm my own child down?"

Children are entitled to protection and care from their caregivers in the areas in which they are not yet able to assume responsibility themselves.

But what about their mothers? "And who takes care of me?" is a legitimate question for mothers who are overburdened and doing their best to do all that is required of them.

What do you think—what does appropriate self-care look like? Check it off.

Mothers should always put their children's needs before their own.	
It is important for children to learn early on that the world does not revolve around them.	
Child-rearing is a give and take: children should look after their mothers as their mothers look after them.	
In principle, the child's needs take priority. Still, mothers should make sure that they also look after themselves.	

Needs

Mothers also have needs: for rest and recovery; for excitement and community; for acknowledgement and self-realization; for romance and sexuality; for support and stability. It is—quite rightly—expected that they suspend their needs in the short term if they conflict with their children's well-being, and this can happen very often to mothers with young children.

Continually unsatisfied needs

Still, a mother whose needs are continually put on hold and thus always the last priority will become more and more unbalanced and dissatisfied over time. This contributes to a stressful atmosphere, and plunges the mother into a vicious cycle: the family's dissatisfaction rises just as the mother is struggling to do everything right. At the same time, the mother's desires and expectations of getting something back for all her sacrifices and efforts rise, too. But this desire often gets frustrated, as an irritated, stressed, and dissatisfied mother often triggers feelings of guilt and anger in her loved ones rather than love and gratitude. In extreme cases, it goes even further: the mother is no longer able to care for herself and her children. This behavior can lead to a "role reversal": the child takes responsibility for her mother, neglecting her own vital

needs and thereby increasing her stress and susceptibility to mental illness. Mothers with BPD have a particularly hard time in this regard, as they were often cared for very little as children and have low self-confidence.

What is Self-care?
Self-care is the willingness and ability to take responsibility for your own well-being. It applies to all areas of life: health, family, work, leisure time, social relationships, and values. Self-care strategies can be subdivided into short- and long-term strategies: for instance, you can spend money on alcohol and tobacco (short-term), or save it for a larger goal, like a vacation (long-term). Short- and long-term strategies often compete with each other. What is good for me in the short term (watching TV, sleeping, eating candy) can jeopardize my long-term strategies (e.g. career prospects). Conversely, long-term goals (e.g. staying healthy) can be harmed if one continually neglects current needs (e.g. rest, sleep, or food).

> **!** Self-care can only work if you value yourself enough to take care of yourself.

Examples of self-care in the areas of:	Short-term strategies	Long-term strategies
health and body	► Take a bath. ► Eat, drink, sleep. ► Go for a walk, go for a bike ride, go jogging. ► Go to the hairdresser's or the beautician's.	► Play sports, move your body ► Eat nutritious food. ► Visit the doctor, care for your health.
social relationships	► Call or write someone. ► Invite someone over or arrange to meet someone. ► Ask someone for help or offer help to someone. ► Solve conflicts.	► Develop and keep up relationships. ► Organize support for yourself. ► Take social responsibility.
leisure time and fun	► Play with children. ► Go out, go to parties. ► Spend time in nature, read. ► Play computer games.	► Develop and keep up hobbies; make time and space for them.
everyday life and family	► Take a short time-out from the family. ► Do small, pleasant activities. ► Tend to things in the household or with your child (clean up, go shopping, cook…).	► Introduce structure and rules. ► Plan activities.

Examples of self-care in the areas of:	Short-term strategies	Long-term strategies
culture and spirit	► Read a book, listen to music. ► Make music, write, draw. ► Go to an exhibition, do some research on a topic.	► Plan culturally and spiritually stimulating activities and incorporate them into everyday life.
work	► Fulfill responsibilities, plan or introduce tasks. ► Solve problems. ► Adhere to a structure.	► Seek career guidance. ► Plan for further training, education, and the future of your career. ► Look for a job.
partnership	► Spend time together, cuddle, flirt, write to each other, give each other gifts. ► Express needs, feelings and desires to each other.	► Focus on your own needs in the partnership. ► Plan pleasant activities and "couple time".
money	► Look for good deals. ► Get rid of unnecessary expenses. ► Do some things yourself.	► Make a financial plan, save money. ► Look for a job.

Quiz question: Come up with one example of how mothers can care for themselves in the short term and one example for the long term.

Record the short- and long-term self-care strategies that you employ every day this week.

Day	Short-term	Long-term

What internal and external obstacles did you have to overcome? What helped you to overcome them?

_____

_____

_____

_____

As your child grows up, what would you like to give him?

Name your most important parenting goals.

Think about how you can achieve these goals (e.g. by being a role model for your child, giving him support).

What hopes do I have for my child?	What can I do to help achieve this?

Name:_____Date:_____

This is an outpatient treatment program designed for mothers suffering from borderline personality disorder.

Orientation and guidelines for the group:

1. The group program comprises 12 sessions, each two hours long, including one introductory and one concluding session.
2. It is strongly recommended that participants receive accompanying individual therapy during the group program.
3. Participation in all group sessions is mandatory. If you cannot attend a meeting, you must cancel in a timely manner using the following phone number:_____
   Unexcused absences will lead to the following consequences:
   _____
   (e.g. paying a fee, speaking with one of the trainers about further participation)
4. The names and personal information of the other participants that are exchanged in the group meeting are strictly confidential.
5. Participation in the group under the influence of drugs or alcohol is not allowed.
6. Assignments must be completed between group meetings.
7. We often make video recordings in order to supervise and improve the quality of our group meetings. In addition, some of the exercises will be recorded on video so participants can receive feedback on their performances. These recordings are strictly confidential, and will be deleted after _____ *(period of time or after the end of the group program).*
8. If not covered by health insurance, the group training costs _____.

I have read the above consent form. I have understood the expectations of the program and I wish to participate in it.

_____   _____
(Signature of Participant)   (Signature of Trainer)

(1) Borderline Personality Disorder and motherhood
Which two factors play in important role in the development of borderline personality disorder?
► Biological factors and an invalidating environment play an important role in the development of borderline personality disorder.

(2) Mindfulness
Do mindfulness exercises always work right away?
► No, they take practice and patience.

(3) The basic needs of children
What is an appreciative attitude toward a child?
► "No matter what you do, you are good as you are" teaches the child that she is valued and respected.

(4) Stress
Are the situations that cause stress the same for everybody?
► No, stress triggers vary from person to person, and depend on how each assesses stressful situations.

(5) Stress management
What are the five steps in the stress management strategy?
► Pause, Breathe, Accept, Distract, Get Active.

(6) Structure and flexibility
Name two (or more) areas in which a young child needs fixed rules.
► bedtime, bodily hygiene, mealtimes, aggressive behavior

(7) Dealing with conflicts
Is there always a 100% correct way to deal with conflicts with children? Is there a single solution that will work in every situation?
► Unfortunately not—even if other people or books trick you into believing there are.

(8) Dealing with emotions
Does accepting your child's feelings mean allowing him to do whatever he wants?
► No—a child is allowed to feel whatever he wants, but not to do whatever he wants.

(9) The importance of the body in parenting
Does a child listen more to *what* you say, or *how* you say it?
► All people, and children in particular, are less attuned to what is said than how it is said.

(10) Basic assumptions about parenting
What questions can you use to test whether a basic assumption is helpful?
► I can ask myself the following questions in order to check if my basic assumption is helpful:
  – Is this thought helpful?
  – Is this thought extreme?
  – Would my friends also see it this way?
  – Is this a belief, or a fact? Would others describe it as a fact?

(11) Self-care
Come up with one example of how mothers can care for themselves in the short term and one example for the long term.
► Short-term measures: going on a walk, calling someone, going out.
► Long-term measures: keeping up contacts, regular physical activity, hobbies.

References

Abela, J. R. Z., Hankin, B. L., Haigh, E. A. P., Adams, P., Vinokuroff, T. & Trayhern, L. (2005). Interpersonal vulnerability to depression in highrisk children: The role of insecure attachment and reassurance seeking. Journal of Clinical Child and Adolescent Psychology, 34, 182-192.

American Psychiatric Association. (2015). Diagnostisches und Statistisches Manual Psychischer Störungen DSM-5. Göttingen: Hogrefe.

Apter, G., Devouche, E., Garez, V., Valente, M., Genet, M.C., Gratier, M., … Tronick, E. (2016). The still-face: a greater challenge for infants of mothers with borderline personality disorder. Journal of Personality Disoders, 1-14.

Barnow, S., Aldinger, M., Arens, E. A., Ulrich, I., Spitzer, C., Grabe, H. J., Stopsack, M. (2013). Maternal transmission of borderline Personality disorder symptoms in the community-based Greifswald Family study. Journal of Personality Disorders, 27(6), 806-819.

Barnow, S., Spitzer, C., Grabe, H. J., Kessler, C. & Freyberger, H. J. (2006). Individual characteristics, familial experience, and psychopathology in children of mothers with borderline personality disorder. Journal of the American Academy of Child & Adolescent Psychiatry, 45, 965-972.

Belsky, D. W., Caspi, A., Arseneault, L., Bleidorn, W., Fonagy, P., Goodman, M., … Moffitt, T. E. (2012). Etiological features of borderline personality related characteristics in a birth cohort of 12-year-old children. Development and Psychopathology, 24(1), 251-265.

Berg-Nielsen, S. & Wichström, L. (2012). The mental health of preschoolers in a Norwegian population-based study when their parents have symptoms of borderline, antisocial, and narcissistic personality disorders: at the mercy of unpredictability. Child and Adolescent Psychiatry and Mental Health, 6(19), 1-13.

Bowlby, J. (1982). Attachment and Loss. Attachment (2nd ed., Vol. 1). London: Hogarth Press.

Breaux, R. P., Harvey, E. A., & Lugo-Candelas, C. I. (2014). The role of parent psychopathology in the development of preschool children with behavior problems. Journal of Clinical Child and Adolescent Psychology, 43, 777-790.

Caspi, A., Sugden, K., Moffitt, T. E., Taylor, A., Craig, I. W., Harrington, H., … Poulton, R. (2003). Influence of life stress on depression: Moderation by a polymorphism in the 5-HTT gene. Science, 301(5631), 386-389.

Crandell, L. E., Patrick, M. P. H. & Hobson, R. P. (2003). »Still-face« interactions between mothers with borderline personality disorder and their 2-month-old infants. British Journal of Psychiatry, 183, 239-247.

Distel, M. A., Trull, T. J., Derom, C. A., Thiery, E. W., Grimmer, M. A., Martin, N. G., … Boomsma, D. I. (2008). Heritability of borderline personality disorder features is similar across three countries. Psychological Medicine, 38, 1219-1229.

Dittrich, K., Bödeker, K., Kluczniok, D., Jaite, C., Hindi Attar, C., Führer, D., … Bermpohl, F. (2018). Child abuse potential in mothers with early life maltreatment, borderline personality disorder and depression. The British Journal of Psychiatry, 213(1), 412-418.

Elliot, R. L., Campbell, L., Hunter, M., Cooper, G., Melville, J., McCabe, K., … Loughland, C. (2014). When I look into my baby's eyes... infant emotion recognition by mothers with borderline personality disorder. Infant Mental Health Journal, 35(1), 21-32.

Ellis, A. (1991). The revised ABC's of rational-emotive therapy (RET). Journal of Rational-Emotive and Cognitive-Behavior Therapy, 9 (3) 139-172.

Eyden, J., Winsper, C., Wolke, D., Broome, M. R., & MacCallum, F. (2016). A systematic review of the parenting and outcomes experienced by offspring of mothers with borderline personality pathology: potential mechanisms and clinical implications. Clinical Psychology Review, 47, 85-105.

Feldman, R. B., Zelkowitz, P., Weiss, M., Vogel, J., Heyman, M. & Paris, J. (1995). A comparison of the families of mothers with borderline and nonborderline personality disorders. Comprehensive Psychology, 26, 157-163.

Florange, J. G., & Herpertz, S. C. (2019).

Parenting in Patients with Borderline Personality Disorder, Sequelae for the Offspring and Approaches to Treatment and Prevention. Current Psychiatry Reports, 21(2), 1-8.

Frankel-Waldheter, M., Macfie, J., Strimpfel, J., & Watkins, C. D. (2015). Effect of Maternal Autonomy and Relatedness and Borderline Personality Disorder on Adolescent Symptomatology. Personality disorders, 6(2), 152-160.

Furman, B. (1999). Es ist nie zu spät, eine glückliche Kindheit zu haben. Dortmund: Borgmann.

Grant, B. F., Chou, S. P., Goldstein, R. B., Huang, B., Stinson, F. S., Saha, T. D., … Ruan W.J. (2008). Prevalence, correlates, disability, and comorbidity of DSM-IV borderline personality disorder: Results from the Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions. Journal of Clinical Psychiatry, 69(4), 533-545.

Gunderson, J. G., Zanarini, M. C., Choi-Kain, L. W., Mitchell, K. S., Jang, K. L. & Hudson, J. I. (2011). Family Study of Borderline Personality Disorder and Its Sectors of Psychopathology. Archives of General Psychiatry, 68(7), 753-762.

Herr, N. R., Hammen, C. & Brennan, P. A. (2008). Maternal borderline personality disorder symptoms and adolescent psychosocial functioning. Journal of Personality Disorders, 22, 451-465.

Hiraoka, R., Crouch, J. L., Reo, G., Wagner, M. F., Milner, J. S., & Skowronski, J. J. (2016). Borderline personality features and emotion regulation deficits are associated with child physical abuse potential. Child Abuse & Neglect, 52, 177-184.

Hobson, P. R., Patrick, M. P. H., Hobson, J. A., Crandell, L. Bronfman, E., & Lyons-Ruth, K. (2009). How mothers with borderline personality disorder relate to their year-old infants. The British Journal of Psychiatry, 195, 325-330.

Kiel, E. J., Viana, A. G., Tull, M. T., & Gratz, K. L. (2017). Emotion socialization strategies of mothers with borderline personality disorder symptoms: The role of maternal emotion regulation and interactions with infant temperament. Journal of Personality Disorders, 31, 399-416.

Kluczniok, D., Boedeker, K., Hindi Attar, C., Jaite, C., Bierbaum, A. L., Fuehrer, D., … Bermpohl, F. (2018). Emotional availability in mothers with borderline personality disorder and mothers with remitted major depression is differently associated with psychopathology among school-aged children. Journal of Affective Disorders, 231, 63-73.

Lenzenweger, M. F. (2008). Epidemiology of personality disorders. Comparative Study. Psychiatric Clinics of North America, 31(3), 395-403.

Levy, K. N. (2005). The implications of attachment theory and research for understanding borderline personality disorder. Development and Psychopathology, 17(4), 959-986.

Lieb, K., Zanarini, M. C., Schmahl, C., Linehan, M. M. & Bohus, M. (2004). Borderline personality disorder. Lancet, 364(9432), 453-461.

Linehan, M.M. (2015). DBT Skills Training Manual, 2nd Ed. New York: The Guilford Press.

Linehan, M.M. (1993). Cognitive-behavioral Treatment of Borderline Personality Disorder. New York: The Guilford Press.

Macfie, J., Kurdziel, G., M. Mahan, R., & Kors, S. (2017). A mother's borderline personality disorder and her sensitivity, autonomy support, hostility, fearful/disoriented behavior, and role reversal with her young child. Journal of Personality Disorders, 31(6), 721-737.

Macfie, J. & Swan, S. A. (2009). Representations of the caregiver-child relationship and of the self, and emotion regulation in the narratives of young children whose mothers have borderline personality disorder. Development and Psychopathology, 21(3), 993-1011.

Macfie, J., Swan, S. A., Fitzpatrick, K. L., Watkins, C. D., & Rivas, E. M. (2014). Mothers with borderline personality and their young children: Adult Attachment Interviews, mother–child interactions, and children's narrative representations. Development and Psychopathology, 26, 539-551.

Marcoux, A. A., Bernier, A., Séguin, J. R., Boike-Armerding, J., & Lyons-Ruth, K. (2017). How do mothers with borderline personality disorder

mentalize when interacting with their infants? Personality and Mental Health, 11, 14-22.

Newman, L. K., Stevenson, C. S., Bergman, L. R. & Boyce, P. (2007). Borderline personality disorder, mother-infant interaction and parenting perceptions: Preliminary findings. Australian and New Zealand Journal of Psychiatry, 41, 598-605.

Petfield, L., Startup, H., Droscher, H., & Cartwright-Hatton, S. (2015). Parenting in mothers with borderline personality disorder and impact on child outcomes. Evidence-based mental health, 18(3), 67-75.

Plass, A. & Wiegand-Grefe, S. (2012). Kinder psychisch kranker Eltern: Entwicklungsrisiken erkennen und behandeln. Weinheim: Beltz.

Ramsauer, B., Mühlhan, C., Müller, J., & Schulte-Markwort, M. (2016). Parenting stress and postpartum depression/anxiety in mothers with personality disorders: Indications for differential intervention priorities. European Child & Adolescent Psychiatry, 25(6), 589-600.

Reinelt, E., Stopsack, M., Aldinger, M., Ulrich, I., Grabe, H. J. & Barnow, S. (2014). Longitudinal Transmission Pathways of Borderline Personality Disorder Symptoms: From Mother to Child? Psychopathology, 47(1), 10–16.

Schacht, R., Hammond, L., Marks, M., Wood, B., & Conroy, S. (2013). The relation between mind-mindedness in mothers with borderline personality disorder and mental state understanding in their children. Infant and Child Development, 22(1), 68-84.

Stepp, S. D., Whalen, D. J., Pilkonis, P. A., Hipwell, A. E. & Levine, M. D. (2012). Children of Mothers With Borderline Personality Disorder: Identifying Parenting Behaviors as Potential Targets for Intervention. Personality Disorders: Theory, Research, and Treatment, 3(1), 76-91.

Stiglmayr, C. (2011). Borderlinestörung. In M. Linden & M. Hautzinger (Hrsg.), Verhaltenstherapiemanual (S. 537-544). Heidelberg: Springer.

Stoffers, J. M., Völlm, B. A., Rücker, G., Timmer, A., Huband, N. & Lieb, K. (2012). Psychological therapies for people with borderline personality disorder. London: The Cochrane Library.

Torgersen, S., Myers, J., Reichborn-Kjennerud, T., Roysamb, E., Kubarych, T. S. & Kendler, K. S. (2012). The Heritability of Cluster B Personality Disorders Assessed Both by Personal Interview and Questionnaire. Journal of Personality Disorders, 26(6), 848-866.

Trupe, R. D., Macfie, J., Skadberg, R. M., & Kurdziel, G. (2018). Patterns of emotional availability between mothers and young children: Associations with risk factors for borderline personality disorder. Infant and Child Development, 27(1).

Weiss, M., Zelkowitz, P., Feldman, R. B., Vogel, J., Heyman, M., & Paris, J. (1996). Psychopathology in Offspring of Mothers with Borderline Personality Disorder: A Pilot Study. The Canadian Journal of Psychiatry, 41(5), 285–290.

Whalen, D.J., Kiel, E.J., Tull, M.T., Latzman, R.D., & Gratz, K.L. (2015). Maternal borderline personality disorder symptoms and convergence between observed and reported infant negative emotional expressions. Personality Disorders: Theory, Research, and Treatment, 6(3), 229-238.

Zanarini, M. C., Frankenburg, F. R., Khera, G. S., & Bleichmar, J. (2001). Treatment histories of borderline inpatients. Comprehensive Psychiatry, 42, 144-150.