Correspondence: Poornima Bhola, Department of Clinical Psychology, National Institute of Mental Health and Neurosciences, Bangalore 560029, India.
E-mail: poornimabhola@gmail.com

Contributions: KM, conception and design, data collection, transcription, analysis and interpretation of data, drafting the article, final approval of the version to be published and agreement to be accountable for all aspects of the work; PB, conception and design, analysis and interpretation of data, revising the draft critically for important intellectual content, final approval of the version to be published and agreement to be accountable for all aspects of the work; GD, conception and design, revising the draft critically for important intellectual content; and final approval of the version to be published; and agreement to be accountable for all aspects of the work.

Conflict of interest: the authors declare no potential conflict of interest.

Ethical approval: all procedures performed were in accordance with the ethical standards of the institutional and/or national research committee (Institutional Ethics Committee, National Institute of Mental Health and Neurosciences, Bangalore, India, Ref no.: (NO. NIMH/DO/IEC BEH. Sc. DIV 2019-2020) and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed consent: informed consent was obtained from all individual participants included in the study including consent for publication.

Data availability: the datasets generated during and/or analyzed during the current study are available from the corresponding author on reasonable request.

Acknowledgements: we would like to thank Dr. Arietta Slade, Professor of Clinical Child Psychology, Yale Child Study Center for permission to adapt the PDI-R.

Conference presentation: a portion of this paper was presented in a symposium titled, On language and culture: Psychodynamic reflections of differences and relationality, at the American Psychological Association Summer Convention, 2021 held virtually on 4th August, 2021.

Citation: Mehrotra, K., Bhola, P., & Desai, G. (2023). Contextualizing motherhood in persons with borderline personality vulnerabilities. Cultural adaptation of the parent development interview revisited in an Indian context. *Research in Psychotherapy: Psychopathology, Process and Outcome, 26*(1), 675. doi: 10.4081/ripppo.2023.675

Received: 18 November 2022.
Accepted: 12 January 2023.
Early view: 3 February 2023.

Publisher's note: all claims expressed in this article are solely those of the authors and do not necessarily represent those of their affiliated organizations, or those of the publisher, the editors and the reviewers. Any product that may be evaluated in this article or claim that may be made by its manufacturer is not guaranteed or endorsed by the publisher.

©Copyright: the Author(s), 2023
Licensee PAGEPress, Italy
Research in Psychotherapy:
Psychopathology, Process and Outcome 2023; 26:675
doi:10.4081/ripppo.2023.675

This article is distributed under the terms of the Creative Commons Attribution-NonCommercial International License (CC BY-NC 4.0) which permits any noncommercial use, distribution, and reproduction in any medium, provided the original author(s) and source are credited.

Contextualizing motherhood in persons with borderline personality vulnerabilities: cultural adaptation of the *Parent Development Interview-Revised* in an Indian context

Kanika Mehrotra,[1] Poornima Bhola,[1] Geetha Desai[2]

[1]Department of Clinical Psychology, and [2]Department of Psychiatry, National Institute of Mental Health and Neurosciences, Bangalore, India

Non-commercial use only

ABSTRACT

An understanding of the complex intersection of borderline personality vulnerabilities and motherhood calls for an integrative and culture-sensitive lens in assessment and therapeutic interventions. The aim of the study was to explore constructions of motherhood in an Indian context to inform the adaptation of the *Parent Development Interview-Revised* (*PDI-R*) for use with mothers with borderline personality vulnerabilities. A stepwise framework was followed to obtain conceptual, semantic, and operational equivalences for the PDI-R adaptation. Interviews on contextualised aspects of motherhood were conducted with a sample of eight mental health practitioners specializing in borderline personality disorders, women's mental health or child psychology, two cultural psychologists, one gynaecologist and one paediatrician. Six emergent themes were identified through thematic analysis, 'The ideal mother and her search for identity,' 'Mothering the mother and the vicissitudes of care,' 'Not just mine - negotiating boundaries,' 'Mother knows best,' 'Food, feeding and embodied nurturing,' and 'Approaching motherhood in the clinic.' The proposed adaptations to the PDI-R were further reviewed by two experts; a clinical psychologist and a psychiatrist specialised in perinatal services. This was followed by the process of operational equivalence through administration of PDI-R with two mothers with borderline personality vulnerabilities and two mothers from the community. The expert review and the administration informed the final adaptation of the PDI-R. A systematic process of adaptation can support the use of measures like the PDI-R in different cultures. A contextual understanding of constructions of motherhood and borderline personality has potential to support meaningful assessment and targeted parenting interventions.

Key words: motherhood; parenting; parent development interview; cultural adaptation; borderline personality.

Introduction

The experience of motherhood is at the meeting point of what is considered universal on one side and deeply cultural on the other. In addition to its' biological aspects, motherhood is

essentially a cultural construction evoking specific social and cultural demands and expectations that are linked with the ideals of family happiness, healthiness, and progeny. One could argue that it is difficult to find another psychological experience that is as intimate and personal as motherhood. At the same time, the way motherhood is lived, understood, and performed depends on how a specific culture conceives who is (and who is allowed to be) a mother and what her role entails. To understand the many cultural ideologies and affects associated with motherhood, we must first acknowledge mothering's nature as a socio-historical, gendered construct (Chodorow, 1978). It is culture that informs meanings ascribed to motherhood, the ways in which it should be experienced, performed and how it should influence relationships and self-identity (Bornstien, 2018).

Motherhood carries a demanding job specification and requires that mothers are in reasonable psychological health (Adshead, 2015). While at times parenting can be difficult for all, it may be particularly challenging for mothers with borderline personality presentations given the associations with insecure attachment patterns, difficulties in emotion regulation and impairments in functioning (Agrawal, Gunderson, Holmes & Lyons-Ruth, 2004; Florange & Herpertz, 2019). Patterns of relating characterized by splitting in combination with enmeshed attachment styles, and unresolved early experiences that are characteristic of borderline vulnerabilities are often situated in the mothers' own early experiences of being parented ((Barone, 2003; Fonagy, Steele, Steele, Muran & Higgit, 1991). Further, these patterns of relating may also be featured in the current mother-child relationship (Newman & Stevenson, 2005).

Parental borderline personality vulnerabilities may be associated with deficits in maintaining safe environments, with empathetic responding, boundary transgressions, deficits in parenting and poor perception of one's own capacities as a parent (Bartsch, Roberts, Davies & Proeve, 2015). Mothers with borderline personality disorder often struggle to make sense of and modulate their own difficult emotional states and are especially vulnerable to stress in the parenting role (Florange & Herpertz, 2019). Mothers with borderline personality disorder may experience lower self-efficacy and satisfaction in the mothering role (Steele, Townsend & Grenyer, 2019) and have difficulties with modelling appropriate emotion regulation strategies, given their own difficulties with emotional regulation (Stepp Whalen, Pilkonis, Hipwell & Levine, 2012). Additionally, research suggests that in mothers with borderline personality disorder, maladaptive parenting is a key mechanism for the intergenerational transmission of psychological vulnerability and negative offspring outcomes (Eyden *et al*., 2016).

Despite these challenges, it is also important to note that many mothers with borderline personality vulnerabilities demonstrate a strong desire to care for their child and want to do their best in this role and identity (Dunn, Cartwright-Hatton, Startup & Papamichail, 2020). This suggests although there is an investment in the wellbeing of the child and motivation to parent effectively, they may need more knowledge or skills to enhance the experience and expression of parenting (Florange & Herpertz, 2019; Stepp *et al*., 2012).

The growing shift from categorial to dimensional models of personality disorders in research literature and current classificatory systems of psychiatric disorders (Zimmerman, Chelminski, Young, Dalrymple & Martinez, 2013) reflect the importance of attending to vulnerabilities even at a sub-threshold level of personality disorder (Kaess Fischer-Waldschmidt, Resch & Koenig, 2017, Cano, Sumlin & Sharp, 2021). In the context of parenting, studies that have included mothers with a diagnosis of BPD as well as those with sub-threshold symptoms suggest the presence of several challenges. For example, even parents with sub-threshold borderline personality vulnerabilities show greater psychological control of their adolescent offspring (Mahan *et al*., 2018), and sub-threshold BPD symptoms in parents are a significant predictor of BPD symptoms in their offspring (Barnow *et al*., 2013).

Some assessment measures used for the inclusion of persons with sub-threshold borderline personality vulnerabilities include the *International Personality Disorder Examination* (IPDE; Loranger, 1999) and the *Borderline subscale on the Personality Assessment Inventory* (PAI-BOR; Morey, 1991) among others. For example, the cut-off of 5 out of 9 for the presence of disorder and 4 out of 9 for the presence of traits on the IPDE has been demonstrated to be a valid method of assessing the presence of borderline personality traits and disorder (Korfine & Hooley, 2009). Similarly, the cut-off score of 38 and above on the PAI-BOR indicates the presence of borderline personality vulnerabilities (Trull & Widiger, 1991).

There have been emergent calls for parenting-focused support for mothers with borderline personality vulnerabilities endorsed by clinicians (Stepp *et al*., 2012) and from the mothers themselves (Dunn *et al*., 2020). Empirically supported therapies for persons with borderline personality do not typically target parenting challenges (McCarthy, Lewis, Bourke & Grenyer, 2016), and the available parenting interventions may not address the specific needs of this population. There is a need for parenting-focused recommendations for mothers with borderline personality vulnerabilities (Zalewski *et al*., 2014, Stepp *et al*., 2012, Florange & Herpertz, 2019), and a comprehensive, culturally relevant clinical assessment can support the development of such interventions.

In this regard, there is a paucity of qualitatively grounded exploration of the lived experiences of mothers with borderline personality vulnerabilities (Dunn *et al*., 2020). Most study designs with mothers with borderline personality vulnerabilities are quasi-experimental, focused exclusively on child outcomes and usually conducted only with mother-infant or mother-toddler dyads (Zalewski *et al*., 2014; Bartsch *et al*., 2015). It is only recently that attention has shifted to mothers with borderline personality pathology and the parenting processes associated with them (Florange & Herpertz, 2019). There is a need for a qualitative examination of the lived experience of the mother with borderline personality vulnerabilities in way that spans the developmental spectrum of the offspring (Stepp *et al*., 2012). A culturally grounded qualitative insight into parenting experience of these mothers can fully capture the depth, variation and detail of these individual experiences and allow for a comprehensive clinical assessment with this population (Dunn *et al*., 2020).

Culture is often conceptualized as a bridge between physical and social environments on the one hand and internal psychic structure on the other, such that every psychological construct or process will have its' cultural underpinnings (Bornstein, 2018). One way to approach culture is through the individualistic-collectivistic heuristic that attempts to differentiate between cultures on the vectors of autonomy and interdependence. Collectivism stresses the importance of community and attention to the needs of others and these cultural values are reflected in parenting beliefs, goals, and practices (Harkness & Super, 2002). The concept of the 'familial self' describes the development of a basic inner organization of the self in a collectivist culture where relatedness and connectedness are seen as paramount facets of the self

Non-commercial use only

(Roland, 1987). In India, a hierarchically organized family is a central unit of social existence and the socialization of children to effectively function as part of this unit is a key goal (Tuli, 2012). This fluid and flexible interdependent self encompasses interpersonal constructs. Self and identity cannot be separated from significant others. Thus, culture and social structures affect identity formation and its diffusion and are best studied in the context of interpersonal relationships (Kagitcibasi, 1996). Cultural context therefore is an integral aspect in the experience of motherhood and borderline personality vulnerabilities.

How does one locate the experience of motherhood at the intersection of borderline personality vulnerabilities and an Indian culture in granular, meaningful ways? What are the relevant areas of enquiry? What are the right questions to ask and to avoid? How to ask those questions? And what is the right language to use? Due to the numerous cultural approaches to motherhood and psychopathology and the complexity of their structures and development, the assessment of these constructs requires an equally integrative and culturally sensitive lens.

One way to assess and explore these themes is through a comprehensive, culturally adapted semi-structured interview. The *Parent Development Interview - Revised* (PDI-R, Slade, Aber, Berger, Bresgi & Kaplan, 2003a) is a widely utilized semi-structured interview aimed at assessing parental representations of the child, themselves as parents, and of the parent-child relationship. The interview strives to tap into parents' understanding of their child's behaviour, thoughts, and feelings, and asks the parent to provide real life examples of charged interpersonal moments: "Describe a time in the last week when you and your child really clicked", and then "a time when you and your child really didn't click". Such questions provide a direct means to evaluate the parent's understanding of their own and their child's internal experience at times of heightened affective arousal. These narratives can allow for a nuanced understanding of the relationship between a parent/caregiver and their child to emerge. Analogous to the Adult Attachment Interview (AAI; George, Kaplan & Main, 1984), the PDI-R is intended to assess internal working models of the current, ongoing relationship with the child. The AAI focuses on individual's capacity to evaluate mental states in her own parents, but not specifically her capacity to keep her child in mind (Slade, Grienenberger, Bernbach, Levy & Locker, 2005b). And while the AAI has been used in research with borderline personality vulnerabilities (Buchheim & Diamond, 2018), studies using the PDI with a focus on the parent-child relationship in mothers with borderline personality vulnerabilities are sparse in research literature.

However, since PDI-R was developed in the American context, it requires a cultural adaptation to ensure its' suitability to an Indian context. It is important to approach a cultural adaptation with the understanding that changes may be required at several levels through a combination of techniques sensitive to the cultural context of the target population (Hambleton, 2001). A conceptually equivalent adaptation may need modification to the structure, process, or the language of administration and the often applied 'single forward and back translation' procedure is an insufficient method for this purpose (Hambleton, 2001). Reichenheim and Moraes (2007) propose a useful framework that encourages rigour and structure to the process of cultural adaptation of a measure developed in a different linguistic-sociocultural context. We use this framework to describe the process of cultural adaption of the PDI-R to the Indian context by establishing conceptual, semantic, and operational equivalencies (Figure 1).

The aims of the current study were twofold. Firstly, to explore and outline the semiotic frames, symbolic resources and cultural meanings ascribed to both motherhood and borderline personality vulnerabilities and disorder. Secondly, to demonstrate the adaptation process of the PDI-R, a semi-structured interview utilized to explore the parents' own representations of the self as a parent, their representations of the child and of the parent-child relationship (Slade *et al*., 2005b) for use in an Indian context with mothers with borderline personality vulnerabilities. The adapted measure will allow for a culturally nuanced comprehensive parenting assessment and the understanding of the motherhood experience within the context of alloparenting, complex family structures, value systems, cultural and social differences found in Indian culture (Tuli, 2012). The adapted measure can support the development of tailormade interventions for mothers with borderline personality vulnerabilities and also has potential for use in future research.

Materials and Methods

Parent Development Interview - Revised

The PDI-R (Slade *et al*., 2003a) is a semi-structured interview examining the parent's ongoing relationship with the child and the parent's understanding of the child's behaviour and their own responses in various situations. The PDI-R is a semi-structured interview with 33 items lasting 60-90 min. It consists of six modules: *view of the child*, *view of the relationship, affective experience of parenting, parent's family history, separation and loss* and *looking behind and looking ahead*.

The PDI has been shown to have strong internal consistency and criterion validity (Sleed, Slade & Fonagy, 2020). It has been utilized in both community (Slade *et al*., 2005b) and clinical settings (Handeland, Kristiansen, Lau, Håkansson & Øie,, 2019), with parents of children in different developmental stages (Borelli, St John, Cho & Suchman, 2016) and with both biological and adoptive parents (León *et al*., 2018). The PDI-R has been adapted for use in Spanish (Fornells, Tésto & Baró, 2018) through a process of translation and back translation with a focus on semantic and cultural and semantic equivalence. It has also been adapted to Hebrew for use with parents of adolescents (Benbassat & Priel, 2012) and has also been adapted to Italian for use with school-aged children (Borelli *et al*., 2016). The Parent Development Interview (PDI) was developed (Aber, Slade, Berger, Bresgi, and Kaplan, 1985) to study attachment in the context of the parent-child relationship and further revised (Slade, Bernbach, Grienenberger, Wohlgemuth & Locker, 2003b). This revised version additionally can be scored for reflective function (RF) on the basis of a coding system explicating a range of RF indicators (Slade *et al*., 2003b, Unpublished Protocol) with specific training available for the RF coding. The PDI-R can also be used as a qualitative measure to assess the parent's narratives for the representation of the child, the parent-child relationship and the parent's ability to mentalize in situations of intense affect for common themes (Kerr *et al*., 2022). Permission was obtained by the author for the use and adaptation of the PDI-R in this study.

Participants

Domain experts

The sample for establishing conceptual equivalence consisted of twelve domain experts was recruited through purposive sampling. Participants consisted of eight mental health

Non-commercial use only

OPEN ACCESS

practitioners specializing in the areas of borderline personality disorders, women's mental health and child psychology, two cultural psychologists, one gynaecologist and one paediatrician, respectively. All participants had a minimum of 10 years of professional experience (M=19.75, SD=9.40, range=10-32 years).

Expert reviewers

The sample for establishing semantic equivalence consisted of two expert reviewers. The first reviewer was a clinical psychologist with 35 years of experience and the second reviewer was a psychiatrist with 27 years of experience. The reviewers had combined expertise in women's mental health, perinatal psychiatry, family therapy, personality disorders and qualitative research and worked in a tertiary care mental health hospital and training institute.

Mothers

The sample for establishing operational equivalence comprised of a total of four mothers; two participants were treatment seeking mothers with borderline personality vulnerabilities or disorder and two mothers were from the community. The participants were aged between 32 and 43 years (M=38.0, SD=4.96) with years of education between 15 and 17 years (M=15.5, SD=1.00). The participants had at least one child between one and twelve years of age (M=6.75, SD=3.86) and had been currently residing with the child for a minimum of 6 months. They were instructed to respond to the interview keeping their eldest child in mind.

Two treatment seeking mothers who met criteria for borderline personality disorder and/or traits on the International Personality Disorder Examination (IPDE, Loranger, 1999) were recruited from the out-patient department of a tertiary care center

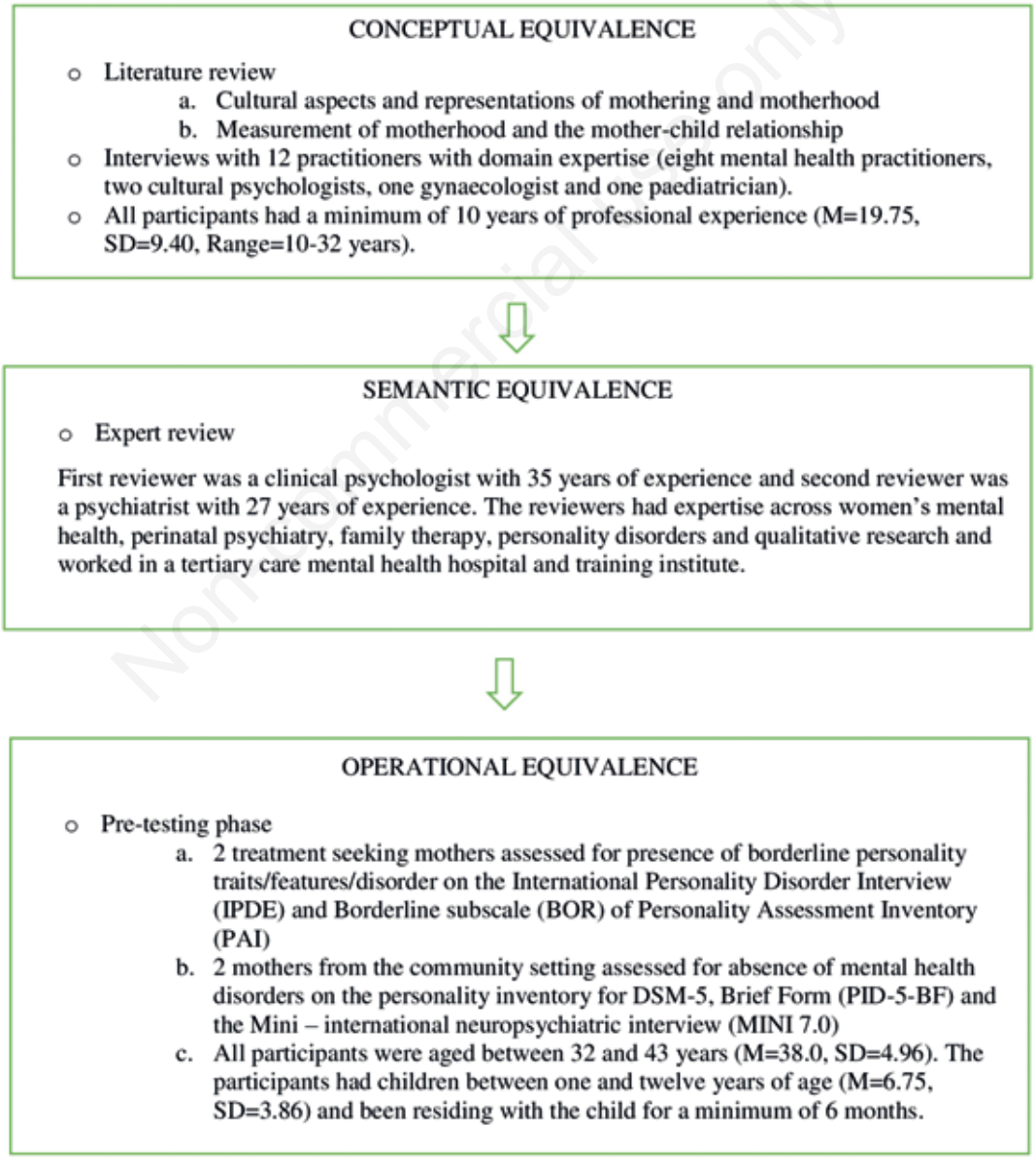

Figure 1. Steps followed in the cultural adaptation of the *Parent Development Interview-Revised*.

Non-commercial use only

in Bangalore, India and were assessed by a licensed clinical psychologist (KM). One mother met criteria for borderline personality disorder (5/9 criteria) and one mother met criteria for borderline personality traits (4/9 criteria). Both mothers met the cut-off score of 38 of borderline personality traits on the Personality Assessment Inventory (PAR-BOR, Morey, 1991) with scores of 54 and 41 respectively. Neither of the mothers recruited in the study had a current diagnosis of psychosis, mania/hypomania, severe depression, substance use disorder, intellectual developmental disorder or neurological conditions. Out of the nine mothers who were contacted, two did not meet inclusion criteria, three withdrew consent and two were lost to follow-up.

Two mothers from the community without any psychiatric illness were recruited for the present study as assessed by a clinical psychologist (KM) for mental health disorders on the *Personality Inventory for DSM-5,* Brief Form (PID-5-BF, Krueger *et al*., 2011) and the *Mini – International Neuropsychiatric Interview* (MINI 7.0.2, Sheehan *et al*., 2014) Of the ten mothers from the community who were contacted, two refused consent due to time or logistical constraints, three individuals met criteria for Axis I disorders on the MINI neuropsychiatric interview and another three had elevated personality traits on at least one of the five domains on the PID-5 BF. These individuals were excluded from the study and provided with information about available psychological services.

Procedure

Permission was obtained from the author for the cultural adaptation of the PDI-R followed by institute ethical clearance for the study (NO. NIMH/DO/IEC (BEH. Sc. DIV)/2020-21). Written informed consent was obtained from all participants. The stepwise framework proposed by Reichenheim and Moraes (2007) for the cultural adaptation of a measure developed in a different linguistic-sociocultural context was followed. This involved i) conceptual equivalence: the process of exploring if the concept covered in the measure is equally meaningful in the new context. Each item/question of the original measure is assessed in terms of its' suitability; ii) semantic equivalence: the process of attending to the meanings of words and grammar used in the original measure with respect to the context in which it is being adapted; iii) operational equivalence: the suitability of the instructions, format, and modes of administration and iv) measurement equivalence: psychometric properties of the adapted measure *vis-à-vis* the original one. In this paper, we address the first three steps of cultural adaptation of a measure.

Establishing conceptual equivalence

In this stage, conceptual literature review and a set of twelve interviews was undertaken. A comprehensive literature review focused on cultural aspects of motherhood, borderline personality and motherhood, and measurement of motherhood experiences informed the following step of preparing interview schedules for the practitioners with domain expertise to explore the intersections of Indian culture, motherhood, and borderline personality vulnerabilities. The aim of this stage was to explore the perspectives of expert clinicians and researchers about how the intersection of motherhood and borderline personality disorder can be conceptualized and captured in the Indian cultural context.

Eight mental health professionals, two cultural psychologists, one paediatrician and one gynaecologist were recruited for audiotaped interviews which took about forty-five minutes to an hour. Semi-structured interview schedules developed by the researchers explored salient aspects of motherhood, relevant socio-cultural influences on motherhood and the mother-child relationship, and specific challenges for mothers with borderline personality vulnerabilities in the mother role. The interview schedules included eight questions common to all participants with an additional set of specific questions based on the specific domain of expertise.

These interviews were audio-recorded and transcribed. Thematic analysis was conducted with the interview transcripts, utilizing a six – step framework (Braun & Clark, 2006) including familiarization with the data, generating initial codes, identifying, reviewing, and defining themes. These emergent themes informed modifications and changes made to the PDI-R by the researchers prior to the expert review (Table 1).

Establishing semantic equivalence

For this phase, two experts reviewed the proposed additions and modifications to the PDI-R. The expert review involved multiple rounds of discussion focused on eliciting comments and suggestions on the following points:

i. Adequate representation of the emergent themes from the interviews of practitioners with domain expertise through the proposed additions and modifications
ii. Relevance of the PDI-R and the proposed modification to the Indian context
iii. Overall content validity of the PDI-R and the proposed changes
iv. Appropriateness and clarity of words and phrases to the Indian context
v. Placement and sequence of the proposed changes

A revised version of the PDI-R was prepared incorporating the comments and suggestions made by the expert reviewers which was utilized in the next phase of establishing operational equivalence.

Establishing operational equivalence

This phase focused on administration of the measure including the format of the adapted PDI-R, instructions, modes of administration, and time taken through the pre-testing phase.

Two treatment seeking participants with borderline personality vulnerabilities and two participants from the community participated in this phase. The adapted PDI-R was administered in person by a licensed clinical psychologist (KM) in a quiet private space and took about two hours to complete. The interviews were audio recorded. At the end of the administration, the participants were asked for specific feedback about i) clarity of instructions, ii) ease of comprehension of the questions, iii) their experience of participation iv) difficulties with a specific word, phrase, or question, if any and v) any other questions that they believed were missing from the interview but warranted inclusion.

Results

The findings are grouped into two sections in keeping with the two aims. The first section deals with the emergent themes from the participant interviews. These illustrate the intersections of motherhood and borderline personality vulnerabilities in an Indian context.

The second section of the results section summarizes the modifications made to the PDI-R informed by the thematic analysis, expert reviewers, and the administration of the PDI-R.

Non-commercial use only

Emergent themes

The ideal mother and her search for identity

The participants illustrated the cultural significance associated with the institution of motherhood. The normative social biography for an Indian woman mandates childbearing after marriage and reproductive capacities are an important source of power, especially when they lack it from other sources. A participant mentioned:

"The notion of motherhood in India is probably the only socially valued role within patriarchal culture – it is the ultimate destiny of the woman. Even more than wifehood, it is motherhood that confers an adult identity to her" (RD, Cultural psychologist)

These constructions of the 'ideal mother' become especially salient in mothers with borderline personality disorder and vulnerabilities who may face stigma and loss of social capital due to their mental illness. At the same time, participants also shed light on the potentially reparative elements of motherhood for mothers with borderline vulnerabilities, as the participants observed:

"In some orthodox Hindu families, women with BPD are not accepted easily. For example, a bahu (daughter-in-law) with BPD with an 'extravagant' personality may not be viewed positively by her in-laws. In that sense, becoming a mother gives her a chance at better support and acceptance from the family." (AD, Perinatal psychiatrist)

"Mothers with BPD do tend to respond to motherhood with positivity, it becomes a source of self-esteem, child becomes the focus… so feelings of unwantedness, emptiness are taken care of, and some amount of cultural and social approval is also gained" (JR, Clinical psychologist)

The self-sacrificing mother as a cultural archetype and consequently as an internalized ideal was also emphasized by the participants. The ideal of the selfless mother was seen through the lens of the specific challenges of borderline personality vulnerabilities. Participants mentioned the difficulties of self and identity as especially problematic. One participant elucidated this clearly,

"The 'mother' metaphor is everywhere in our culture – mythology, stories, movies, cultural idioms and is a tough image to live up to – this self-sacrificing person who sacrifices herself in the interest of the child" (SM, Cultural psychologist)

Participants highlighted the difficulty that mothers with borderline personality vulnerabilities may have in integrating parental self-efficacy which refers to the parents' belief or judgements about their capability to undertake parenting tasks (Mon-

Table 1. Interview schedule for domain experts.

Questions for all domain experts	
1.	What are the elements of a realistic and healthy (good-enough) mother-child relationship?
2.	What factors (internal and external) affect a mother's ability to recognize and respond to a child's emotional cues?
3.	What are the typical caregiving structures for children that you have seen in your professional experience?
4.	What are the cultural factors (roles, expectations, processes) that influence a mother-child relationship? In your experience, what are some of these cultural factors that are visible in the clinic?
5.	In what ways does the mental health (borderline personality vulnerabilities) of the mother have an impact on the mother-child relationship?
6.	What is the role of early experience of being parented on the mother's current experience of parenting? (In general, and in mothers with borderline personality vulnerabilities)?
7.	How do mothers tune in/connect with what the child may be thinking and feeling (in infancy, childhood and adolescence)? Can you illustrate with some examples?
8.	What are the kinds of questions that can elicit mothers' reflections on their child's internal world and their relationship with the child?
Additional questions for mental health professionals	
1.	In what ways may borderline personality vulnerabilities (in the mother) reflect in the mother-child relationship?
2.	What are some concerns that mothers with borderline personality vulnerabilities bring to the clinic?
3.	How do mothers with borderline personality think about and evaluate themselves in the mother role?
Specific questions for cultural psychologists	
1.	It is argued that the role of mother is historically and socially constructed. What are the constructions of motherhood in the Indian context?
2.	What are the expectations from and of a mother specific to the Indian context?
3.	What is the type of relationship most Indian mothers expect/hope to have with their child over the different developmental stages of the child?
4.	Who is involved in 'raising a child' and how do these others impact the experience of motherhood?
Specific questions for gynaecologists	
1.	What are some indicators of mother-baby bonding in pregnancy?
2.	Are there any red flags that you look for in a pregnant woman that would indicate referral to a mental health professional?
3.	What are some questions that can capture important aspects of pregnancy experiences?
Specific questions for paediatricians	
1.	What are some of the concerns and difficulties that a mother may have with regard to the mother-child relationship?
2.	What are some indicators either from the parent or the child (or both) that may indicate challenges in the parent-child relationship?
3.	Do mothers speak of mother-child relationship difficulties with the paediatrician? Are there any suggestions that you typically offer to help with this?

Non-commercial use only

tigny & Lacharite, 2005) with the culturally prescribed notions of the 'ideal' or 'good 'mother. As illustrated in these excerpts:

"There is this pervasive pressure and a kind of compulsion to keep the child's needs over and above her own – therefore she cannot be tired, she cannot be irritable, she cannot want to not cook – this whole notion of branding a woman as a 'bad mother', if she is just being human sometimes – it is a very common, cultural prevalence" (RD, Cultural psychologist)

"Mothers with BPD have difficulties in evaluating themselves as a mother, they have a pre-set template of what a mother should be in narrow, idealized definitions. These can be problematic when they aren't able to live up to them." (AH, Psychiatrist & Psychoanalyst)

Participants raised concerns that difficulties with splitting into 'good 'and bad,' may not only be limited to the mother's sense of self but also in her perception of her child. Experts highlighted the expectations that may also be placed on the child. One participant spoke of this idealization-devaluation dynamic with the child:

"Mothers with BPD also idealize their child – and they my see the baby as means to strengthen their relationship with the husband or solidify their position in the family – so expectations from the baby may be high – lovable baby, good baby, baby will fix my marriage" (KD, Perinatal psychiatrist)

"In mothers with BPD, a lot of their identity is tied to the child – her self-esteem may be based on the child's adamic performance, behaviour with others. All of these can be problematic" (IC, Clinical psychologist)

Some participants connected the expectation of a mother's ability to put her child's needs above all else, with difficulties related to emotion regulation.

"At some points (the mother) may get carried away in her own struggles … fighting with husband or relatives for three, four days together, experience intense emotion and neglect the child completely" (DC, Clinical psychologist)

The participants highlighted the role of intergenerational transmission of pathology, which could potentially increase the demands on a mother with pre-existing borderline vulnerabilities.

"Often the infants of these mothers, by genetic load may be of a more difficult temperament, crankier and more irritable which is an added stress to these mothers, this causes them distress and then they are not able to soothe themselves – which causes the child distress, and she isn't able to soothe the child. This is also when she may look at herself as a bad mother" (MN, Clinical psychologist)

Mothering the mother and the vicissitudes of care

Participants discussed a common ritual of Indian women going to their own natal home usually around the seventh month of pregnancy and staying till several months after the child is born. A married woman spending a length of time at one's natal home is otherwise usually frowned upon, and therefore rare. This cultural practice, specifically during pregnancy underscores the idea of the expectant mother being mothered in ways that prepare her in turn to become a mother. Culturally, the natal home is seen as an enduring source of succourance and support, and this is often contrasted with the relationship the mother might share with her family of procreation. As a participant stated:

"Mothers will often speak about the role of 'Nani' (maternal grandmother), fondly– in most of my work, mothers have been unanimous in voicing that their own mothers really understand the minutiae of their own struggles. It is within the maternal home that the mother feels understood, finds empathy. It is an irreplaceable bastion of support for the mother" (RD, Cultural psychologist)

"The practice of the mother going back to her maternal home – the place she grew up as a child – I see that as an incredibly positive practice because here it is assumed that my mother will care for my baby for my comfort. My mother-in-law on the other hand will be taking care of the baby for the baby's sake and her son's sake" (SM, Cultural psychologist)

Pregnancy is a sensitive period where past attachment systems are easily activated. Given disrupted attachment and trauma histories associated with borderline personality vulnerabilities, this cultural practice becomes a complex site of negotiation for vulnerable mothers. A participant elucidated:

"New mothers often spend a considerable time in their maternal home, and it is there that she is taken care of, and her baby is taken care of such that she is able to heal, bond with her infant without having to worry about house-hold work. She is able to have what we call a 'primary maternal preoccupation.' Mothers with BPD often do not get along with their own mothers, family of origin … this definitely adds to her burden of care" (BX, Child psychiatrist)

This theme is further explicated where a participant highlights pregnancy and the act of becoming a mother as a critical time during which family systems with pre-existing vulnerabilities may be disrupted and attachment difficulties with primary attachment figures are magnified. As the participants stated:

"In times of becoming a mother – the pathology in the family of a mothers with mental illness gets highlighted straightway (post-natal). Like, the grandparents become more distressed rather than supportive – which becomes the focus rather than the new mother or the baby – it becomes apparent where the pathology is coming from" (CQ, Gynaecologist)

"The practice of going back to one's own mother's house during the final months of pregnancy are problematic for the mother with BPD. One of my patients' felt her anxiety about her mothering skills shoot up when she saw her own mother look after her newborn – so getting thoughts like, my mother can care for my child, but not me. Emotions of insecurity and competition with her own child arose" (KD, Perinatal psychiatrist)

Participants also spoke about social support that is traditionally available to mothers in the Indian culture, but out of reach for a mother with fraught inter-personal relationships with her family.

"Difficulties (mothers with BPD) with her own mother are common, if I am a mother with borderline vulnerabilities and a not-so-great history with my mother, I don't want her to be too involved. But on the other hand, there may also be too much dependence, so that confidence in her own abilities doesn't come up" (IC, Clinical psychologist)

Participants linked the culturally prescribed expectation of availing child-rearing support from family members with negative consequences for mothers with unstable attachment histories, often observed in mothers with borderline personality vulnerabilities.

"Not having a good relationship with family of origin is

something I have seen over and over again in mothers with BPD. It plays out in terms of support, a woman having a baby is at a particularly vulnerable point in her life, if she has burnt all her bridges and there is no support then it can be incredibly hard" (BX, Child Psychiatrist)

"Mothers with BPD (borderline personality disorder) often find themselves isolated, they tend to see any kind of involvement from extended family as an intrusion – this has consequence on availability of support" (DC, Clinical psychologist)

Not just mine: negotiating boundaries

Alloparenting or the care of children by people other than the mother is an integral part of family organization in India. A collective identity where the sense of self draws from the internal presence of a constellation of 'others' is emphasized. Participants reflected on the presence of all these myriad others – fathers, grandparents, aunts, and uncles and hired help.

"Motherhood is shared and complex – the one child and one caregiver model treated as the 'norm' in academia is uncommon" (SM, Cultural psychologist)

Experts further emphasized the role of technology in the active participation of extended family members in child rearing even in families with a nuclear structure.

"Most mothers have good family support, and the joint family is still thriving, even if not in immediate geography, but through the phone. The evoking of other family members is a very strong tendency. If mother puts on a frock on the child she may say, 'see, isn't Masi's (maternal aunt) gift lovely?'" (RD, Cultural psychologist)

The child's close bonds with extended family members were understood through the lens of the culturally informed expectation of shared child rearing.

"As a mother, if I don't share my child I am seen as too controlling and it is not good for the child. The focus is on making the child aware that the mother is going to be only one of the many adults that you are going to experience" (RD, Cultural psychologist)

The expectation of 'sharing the child' can be problematic for mothers who may grapple with fears of abandonment that can be magnified when the child forms close bonds with others. There is also a fear that others family members may completely take over the care of a child if the mother has a mental illness. As two of the participants elucidated:

"If my patient has had an argument with a family member but her son, who is only 1.5 years old wants to be with this person or wants to communicate with him – she feels betrayed and abandoned by the child" (MN, Clinical psychologist)

"Care-giving roles are generally divided. When there is a mental illness in the mother, she is conveniently sidelined, then mother does not get a chance to experiment with her mothering fantasies. This can be a positive initially but in the long run it can get problematic" (AD, Perinatal psychiatrist)

Theme: mother knows best

Given the interdependent, collectivist structure of Indian culture, parents are more likely to encourage children to view themselves as part of the integrated whole of their family and community, and not to emphasize their differences. As a participant mentioned,

"In India there much less mentalization of the child… we do not really ask the child, you like this? Do you want this? Far more focus is placed on how the child is behaving rather than what is going on in his head… whatever is going on in your head, behave like this please… I think we are far more focused on interpersonal relationships than mental states as a culture." (RD, Cultural psychologist)

Participants underlined the cultural nuance required in interpreting the meaning of 'boundary' in Indian interpersonal relationships, with special focus on the mother-child relationship.

"I don't think boundaries is a borderline thing. All Indian parents overtake boundaries, we are culturally told not to have boundaries. If you say for example, as a parent, I am going to sleep in my bed and my 3-month-old baby is going to sleep in his own crib – all hell is going to break loose." (IC, Clinical psychologist)

Participants contrasted the concepts of boundaries and separateness within the mother-child dyad in the Indian context with borderline personality vulnerabilities. They illustrated an added layer of complexity of this cultural nuance to a mother who may already be grappling with mentalizing deficits (as is hypothesized in persons with borderline personality vulnerabilities). For example, her need for closeness may be absorbed within this 'cultural allowance', on the other hand it may add to the challenges associated with critical developmental stages in the child-like toddlerhood and adolescence.

"In India, in many ways we don't really think of the child as being a separate person in any case… Even if you take things like feeding, satiety is not really determined by the child but by the parent. So, all that essentially means the child's individuality is not appreciated especially in the first two years of life. It is possible that BPD vulnerabilities and culture come together to make this distinction even harder for this population" BX (Child psychologist)

"It is hard for a mother who anyway has trouble with boundaries, she is also getting cultural signals that it is OK to not have all these boundaries with the child. It can be threatening for her to see 'otherness' in her child. Given their rocky interpersonal history, they may come into this role with tremendous expectation and investment" JR (Clinical psychologist)

Food, feeding and embodied nurturing

Food and mealtimes are at the heart of the Indian family ritual and is a rich space for understanding embodied motherhood. A good mother is often understood to be one who can cook and feed her child with wholesome, home-made food on demand.

"There is this dramatic attention to food in India – this thing that the child has the mental capacity to know when she or he is hungry – we just don't care about that. The first thing that a mother does when a child returns from school is check his tiffin box. If the mother does not send her child to school with a home-made packed lunch, she is seen as wicked almost, that is a zone of no tolerance… 'Kya khaya' (what did you eat?) is a standard question – part of the culture." (SM, Cultural psychologist)

"Feeding is a much more salient activity than schedul-

Non-commercial use only

ing the child's life – schedule is not God like, or anything like in other countries. If some relatives come over, it is okay…we will keep the baby awake. This is not a zone of no tolerance" (RD, Cultural psychologist)

Approaching motherhood in the clinic

Participants underscored the importance of focusing on strengths and positive aspects of mothering, especially when exploring mothering experiences of marginalized individuals along with including contextualized, situation specific questions in the interview to allow for more accurate representation of lived experiences including moments of high emotional arousal or conflict. Questions that are grounded in the day-to-day experience of mothering can provide more specific information about areas of possible therapeutic focus.

These themes further informed the modifications and additions that were made to the PDI-R for use with mothers having borderline vulnerabilities in the Indian context.

Cultural adaptation of the PDI-R

Table 2 elucidates the additions and modifications made after the completion of the phases on conceptual, semantic, and operational equivalencies. The changes include insertion of additional modules, questions or probes and modifications to existing words or phrases.

A new module focusing on the experience of expecting the child was included and it was made sure that the questions in this section were inclusive of experiences besides biological birth, including adoption and surrogacy. Additional questions were included in modules including *view of the child*, *view of the relationship*, *affective experience of parenting* and *parent's family history*. Additional probes were added to several questions to elicit the reactions and views of others (*e.g.,* extended family) to reflect the cultural reality of multiple caregivers. Alternate probes were suggested for questions eliciting feelings such as anger and rejection toward the child due to culturally based negative connotations associated with these emotional states in the context of motherhood. Alternate words or questions were also included for words and phrases flagged as potentially vague or ambiguous for the local population.

Discussion

Understanding the way a mother perceives, experiences, and interprets her child, her relationship with the child and her own self as a mother is valuable to both the researcher and the clini-

Non-commercial use only

Table 2. Summary of adaptations made to the Parent Development Interview-Revised (PDI-R).

PDI-R (Original)	PDI-R (Adapted)
Expecting your child (new module added)	3 questions exploring the time during pregnancy, or expecting the child through adoption or through surrogacy Representative themes include (a) self/other expectations of motherhood, (b) caregiving structures and (c) cultural rituals associated with pregnancy
View of the child	
5 questions	7 questions. New questions representing (a) themes exploring role of multiple caregivers and (b) centrality of food in determining parenting practices
Q5. What do you like least about your child?	Question modified to 'What is your least favourite thing about your child'?
View of the relationship	
4 questions	8 questions. New questions representing culture specific (a) expressions of parental affection, (b) parenting styles (c) nature of involvement of other caregivers and (d) the mother's negotiation of the relationship of her child with other caregivers
Q1. I'd like you to choose three adjectives that you feel reflect the relationship between you and your child	'Could you describe your impressions of the relationship between you and your child?' was added as a more open-ended alternative
Q2. Describe a time in the last week when you and (your child) really 'clicked'	The phrases 'really got along', 'were on the same page', 'felt connected', were added as descriptors to the word 'clicked'
Affective experience of parenting	
14 questions	18 questions. New questions representing (a) self-perception of strengths as a mother (b) self-perception of challenges as a mother (c)negotiation of mother-role with relationship with spouse and (d) relationships with other family members.
Q6. Tell me about a time in the last week or two when you felt really angry as a parent	The phrase 'felt really angry' was modified to 'felt really upset as a parent'
Parent's family history	
5 questions	6 questions. New question focusing on other caregivers (extended family members, hired help)
Q1. How do you think your experiences of being parented affect your experience of being a parent now?	The phrase 'being parented' modified to 'being brought up and raised'
Separation/loss	No modification
Looking behind/looking ahead	No modification

cian, especially as we begin to conceptualize parenting as a pathway to the intergenerational transmission of pathology, attachment and resilience (Stepp *et al*., 2012).

A qualitative component can add depth and richness to a structured assessment and allow for a more nuanced and authentic engagement with a patient's experience of motherhood. An interview embedded in specific cultural parenting scripts can elicit narratives about the ways in which a mother envisions her child's thoughts and feelings, emotionally charged interactions with the child and the quality of representations of the child and herself as a mother.

When considering the parenting experience for a mother with borderline personality vulnerabilities, it is important to first consider the dominant cultural ideologies of motherhood. Indian mythology and cultural symbols glorify women's role as a mother as the benevolent mother goddess, deified and idealized both in a literal and figurative sense (Aneja & Vaidya, 2016). From the mother-goddess of Hindu mythology to the earth mother of Bollywood, the deification of 'maa' or the maternal-feminine underscores the cultural codification of the mother in the Indian context. It is through this socio-political and cultural ideology of motherhood that the Indian mother must negotiate the vicissitudes of her lived experience. 'In Hindi, there is a special word reserved for referring to a mother's devotion to her child – 'mamta.' Mamta has interesting etymological origins – in Sanskrit it is derived from mamtava, or the love of the self – but over time it has emerged to imply its exact opposite – selfless love for the child. This transformation suggests a dialectic – that the child is so much a part of the self, that loving your child is loving yourself; and its' opposite that the self actually dissolves in the loving of the child' (Chaudhary, 2015, p. 288).

Given the cultural idealization of 'mamta' and the cultural expectations associated with motherhood, it is important to reflect on how one can approach this experience sensitively. Choi Henshaw, Baker & Tree (2005) found that mothers can compare themselves to this idealized narrative and feel inadequate. Both, the content of the questions asked as well as the language used to ask those questions has import on what the mother may choose to articulate (or leave unspoken) and her felt experience of being heard and understood.

For example, in an Indian context, the expression of negative emotions such as anger (Vidhatri Rawal & Martini, 2009) or dislike towards the child or the tasks associated with child rearing may be considered inappropriate or unacceptable, a view also endorsed by the expert review committee as part of the process of adaptation. We ensured that the words and phrases in the PDI-R were sensitive to these connotations. For example, the question, 'tell me about a time when you felt really angry as a parent?' was modified by substituting the word 'anger' with 'feeling upset.' Similarly, the question 'What do you like least about your child,' was modified to 'what is your least favourite thing about your child?' We hope these modifications invite the exploration of these relevant aspects of motherhood in a manner better suited to an Indian context.

Although most psychological theory and literature compel an almost exclusive focus on the mother-child dyad, models of care can vary in different cultures. A key feature of child rearing in India is the strong preference for multiple caregivers, and children are usually brought up with the involvement of many (Keller *et al*., 2018). The practice of alloparenting (Wilson, 1975) is defined as parental care towards non-descendant young and multiple mothering including (but not limited to) extended family, hired help and neighbours is common in the Indian context. In fact, a mother who is alone in bringing up her child may be perceived as lacking support (Keller *et al*., 2018) or as 'harming the child', as was an emergent theme in the interviews with practitioners.

Therefore, the additional questions included to this cultural adaptation of the PDI-R invite information about other people, particularly family members, the family unit being a cornerstone of Indian personal–social reality (Chaudhary & Bhargava, 2006). This involvement of others is not only a part of a mother's experience of raising her child, but also a part of her own experience of being raised. Changes to terms such as 'being parented' to 'being raised and brought up' reflect this cultural understanding of child rearing as a shared responsibility. While some of the questions invite the presence of others in a direct manner like, 'Who are the other people involved in the care of your child?' questions like, 'who (in your family) do you think your child resembles?' invite the presence of others in a more indirect manner. We believe that this variation in the manner of questioning allows for multiple entry points to the inexorable link between the mother's sense of self and the internal presence of the other, an integral aspect of a culture that places value on harmony and family integrity (Triandis, 1996).

We believe that inviting narratives about the 'others' involved in the child's care is of tremendous importance in the context of mothers with borderline personality vulnerabilities and disorder. Given the associations of borderline personality pathology with adverse childhood experiences including trauma, abuse, and neglect, fraught attachment history, interpersonal challenges, and lack of social support (Steele *et al*., 2019), these culturally significant interpersonal contexts form a noteworthy area of enquiry.

For the adult with borderline personality vulnerabilities, the transition to parenthood can be an especially challenging experience. Pregnancy may be unplanned and in the context of interpersonal conflict (Newman and Stevenson, 2005). The desire to become a parent may be ambivalent and may involve conflicting motivations such as the desire to care, the need to be cared for and a compulsion to re-enact or rework early traumatic attachment experiences (Blankley, Galbally, Snellen, Power & Lewis, 2015).

The normative social biography for the South Asian woman mandates childbearing after marriage (Bhatti & Jeffery, 2012) and is an important source of her identity, "May you bathe in milk and bloom among sons" (milk, meaning motherhood, and sons, symbolizing prosperity) is a traditional blessing bestowed on young women in India (Chaudhry, 1997). South Asian women are expected to adjust to a new family, conceive a baby (preferably a son) and become a mother as soon as possible. If they do this successfully, they have proved their fecundity, given an heir to their husband's family and secured their position in the household (Bhatti, 2012). These social interpretations of gender, familial power structures, and agency over reproduction and fertility can be deeply definitive of the overall experience of motherhood (Uberoi, 1993).

In the process of adaptation of the PDI-R, the expert review committee and practitioners highlighted the significant import of the experience of pregnancy on the subsequent experience and meaning making of motherhood in the Indian cultural context. With this clinical and cultural background in mind, we included a new module with three questions that we named *'expecting the child.'* An interview that captures the process of 'becoming' a mother to being a mother, *i.e.*, capturing the narrative from conception to the on-going, live relationship with

the child can be a powerful entry point into a patient's experience of motherhood. Is the narrative rich, coherent, and consistent? What is the emotional tone of the narrative? Are there any recurrent themes? Answers to these questions can provide information that informs future therapeutic interventions.

It is important here to mention the Pregnancy Interview (Slade, 2011), a semi-structured interview analogous to the PDI-R administered to the expectant mother during her third trimester. It is used to capture the expectant mothers' representations and fantasies of herself as a carer and of her child. In order to chart a mother's journey from pregnancy up to the present day, this additional section is intended as an augment to the PDI-R in order to facilitate this process.

The additional questions were framed keeping in mind culturally significant antenatal and postnatal rituals. As with all cultures, certain practices are associated with pregnancy, childbirth, and new-born care in India. Foods to eat, activities to avoid, and care and behaviour during delivery and the postpartum period are all culturally prescribed (Choudhry, 1997). For example, there is an assumption that the expectant mother will return to her natal home for care in the antenatal and perinatal periods. Being supported by her own mother in the 'safe space' of the natal home is a culturally legitimate practice during this time. It is common for husbands to visit on and off while women stay in their natal home for several months. Other aspects of the natal home that are supportive include the fact that for many women, childhood friends and extended family still live in their natal homes (Raman *et al*., 2014).

This cultural expectation of the natal home being a source of support to the expectant or new mother is especially meaningful when exploring the motherhood experiences of mothers with borderline personality vulnerabilities who often carry difficult developmental histories and attachment injuries (Quek *et al*., 2017). Existing questions in the section on *'parent's family history'* along with newer questions focusing on involvement of others' in childcare and the rituals of returning to the natal home for postnatal care can combine to provide windows to inter-generational patterns in the experiences of Indian mothers with borderline personality vulnerabilities.

Diverse cultures carry with them their unique ethnographies associated with parenting, and food related beliefs and practices in the context of childcare is a powerful window into an Indian mother's experience. The 'good' mother is one who feeds the child on demand with wholesome home-made complex foods of the particular ethnic and caste-based group of the patriliny (Srinivas, 2006). A high level of regulation of the child's eating behaviours including what, when, how and with whom is generally reported as an Indian mother's central preoccupation (Tuli, 2012). Eliciting Parenting practices that are specific to the culture to which they belong can provide essential information about the communication of care, the dynamic of the family system and embodied nurturing. We hope that the inclusion of questions like, 'what are mealtimes like with your child?' invite rich, contextually grounded narratives from our participants.

The current paper emphasizes the nuance required in working at the intersection of the culturally mediated states of motherhood and borderline personality vulnerabilities. Borderline personality disorder may be seen as disorders of self-regulation and attachment with chronic difficulties in emotional regulation, self-cohesion and maintaining relationship attachment figures. These core features of personality disorder likely have an impact on parenting and the capacity to manage emotional responses to the child, to process the child's communication and to promote attachment security and healthy child development (Newman & Stevenson, 2005). The present study identifies some of the cultural scripts inherent in the constructions of motherhood. Attending to the way in which motherhood is lived by a mother with borderline personality vulnerabilities becomes critical, especially in the clinic where meaning making is a joint process informed by unique cultural backgrounds, distinct subjective experiences, family situations and social environments. A clinical measure that allows the patient with borderline personality vulnerabilities to communicate her experience of motherhood contextualised within the parenting beliefs, values and practices of her specific culture can be an invaluable assessment tool for a clinician. It can help build bridges of connection with the patient and inform future intervention. This sentiment was also reflected in the feedback provided by the mothers who participated in the interview. They communicated a deep appreciation for the space provided by the interview to reflect on their experience of motherhood, which they believed to be lacking when interfacing with healthcare professionals.

The rigour applied to the process of cultural adaption of the PDI-R is an important strength of the study. This multi-step process required for participants to be recruited at various stages. These included practitioners with domain expertise, mental health and qualitative research experts, mothers from the community and mothers diagnosed with borderline personality vulnerabilities. This wide gamut of participants allowed for insights about the cultural aspects of motherhood, family structures, culturally sanctioned role of women, and the complex interplay of socio-demographic variables with borderline personality vulnerabilities to emerge. The current adaptation of the PDI-R can lend itself to nuanced explorations of motherhood in the Indian context with varied populations both in the clinical and community settings.

The process of adaptation is significant in ensuring the cultural integrity of a study. However, usually little is reported in research publications about the adaptation process making it difficult for journal readers to adequately evaluate the process. This is also true of previous adaptations of the PDI-R (Fornells *et al*., 2018; Benbassat & Priel, 2012; Borelli *et al*., 2016). The current paper aimed at providing an example of a detailed and systematic method for the cultural adaptation of a qualitative measure, the PDI-R.

Since the study was conducted in a specific, South Indian urban context in English with a small sample, the transferability of this cultural adaptation is limited. Including mothers from the community and those with borderline personality vulnerabilities as participants in all the stages of the study - including establishing conceptual and semantic equivalencies would have strengthened the process of adaptation.

Conclusions

A culturally informed qualitative examination of the intersectionality of motherhood and borderline personality vulnerabilities is imperative in the clinical assessment of mothers with borderline personality vulnerabilities. The emergent themes from the interviews vividly illustrate the vast cultural, social, inter and intrapersonal terrains that the experiences of motherhood and borderline personality vulnerabilities straddle. A contextual understanding of motherhood as a site of negotiation and meaning making is important not only in research endeavours but also in treatment with mothers with borderline personality vulnerabilities.

The adapted PDI-R allows for the clinician to assess relevant themes in mothers with borderline personality vulnerabilities suited to their stage of motherhood and specific symptomatology. This can include affect tolerance, self-regulation and the impact on patterns of parenting (Allen, 2018), own experiences with attachment figures (Mosquera, Gonzalez & Leeds, 2017), perception of their own strengths and weaknesses as a parent (Bartsch *et al*., 2015) and key moments of interactions with the child situated within a contextually relevant experiential account of motherhood. This assessment can be a cornerstone for designing tailormade parenting-focused clinical interventions. Additionally, the cultural adaptation of a widely utilized measure such as the PDI-R also allows for future cross-cultural research, collaborations and comparisons in a way that continues to be useful in local settings. This adapted measure has a wider scope for use in future process and/or outcome studies that examine parenting experiences and in explorations of motherhood in India that are not necessarily restricted to borderline personality vulnerabilities.

In the future, the current adaptation can be further refined through the process of 'cognitive interviewing' which involves the administration of the drafted questions while also collecting information about these questions (Beatty & Willlis, 2007). As we begin to use this version with Indian mothers, collecting information of the participant views of the content and phrasing of the questions may allow for further modification. Measurement equivalence, *i.e.*, establishing the psychometric properties of the current adaptation of the PDI-R is also a crucial step for the future. Since this adaptation was focused on exploring experiences of mothers, further modifications may be needed for its' use with fathers.

The adapted version of the PDI-R as well as the detailed steps followed to ensure methodological rigour and cultural integrity in the process of adaptation may also be applicable to other cultures with similar constructions of motherhood and parenting. Given that both parenting and borderline personality vulnerabilities are deeply embedded in cultural and situational contexts, using a measure adapted to the culture is an important first step in the development of culturally sensitive and relevant assessment protocols and interventions for mothers with borderline personality vulnerabilities.

References

Aber, J. L., Slade, A., Berger, B., Bresgi, I., & Kaplan, M. (1985). *The Parent Development Interview. Unpublished Manuscript.* Barnard College, Columbia University, New York.

Agrawal, H. R., Gunderson, J., Holmes, B. M., & Lyons-Ruth, K. (2004). Attachment studies with borderline patients: A Review. *Harvard Review of Psychiatry*, *12*(2), 94-104.

Allen, J. G. (2018). *Mentalizing in the development and treatment of attachment trauma.* London, England: Routledge.

Aneja, A., & Vaidya, S. (2016). *Embodying motherhood: Perspectives from contemporary India* (pp.1-29). New Delhi, India: Sage Publications India.

Bartsch, D. R., Roberts, R. M., Davies, M., & Proeve, M. (2015). Borderline personality disorder and parenting: clinician perspectives. *Advances in Mental Health*, *13*(2), 113-126.

Barone, L. (2003). Developmental protective and risk factors in borderline personality disorder: A study using the Adult Attachment Interview. *Attachment & Human Development*, *5*(1), 64-77

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.

Beatty, P. C., & Willis, G. B. (2007). Research synthesis: The practice of cognitive interviewing. *Public Opinion Quarterly*, *71*(2), 287-311.

Benbassat, N., & Priel, B. (2012). Parenting and adolescent adjustment: The role of parental reflective function. *Journal of Adolescence*, *35*(1), 163-174.

Bhatti, F., & Jeffery, R. (2012). Girls' schooling and transition to marriage and motherhood: exploring the pathways to young women's reproductive agency in Pakistan. *Comparative Education*, *48*(2), 149-166.

Borelli, J. L., St John, H. K., Cho, E., & Suchman, N. E. (2016). Reflective functioning in parents of school-aged children. *American Journal of Orthopsychiatry*, *86*(1), 24-36.

Bornstien, M.H (2018). Some metatheoretical issues in culture, parenting and developmental science. In: Jing, Q., Rozenweig, M.R., d'Yewalle, G., Zhang, H., Chen, H., & Zhang, K (eds.), *Progress in Psychological Science around the World*, vol.2 (pp. 85-94). New York: Routledge

Blankley, G., Galbally, M., Snellen, M., Power, J., & Lewis, A. J. (2015). Borderline personality disorder in the perinatal period: early infant and maternal outcomes. *Australasian Psychiatry*, *23*(6), 688-692.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101.

Buchheim, A., & Diamond, D. (2018). Attachment and borderline personality disorder. *Psychiatric Clinics*, *41*(4), 651-668.

Cano, K., Sumlin, E., & Sharp, C. (2021). Screening for borderline personality pathology on college campuses. *Personality and Mental Health, 16(3),* 235-243.

Chodorow, N. (1978). *The reproduction of mothering*. University of California Press.

Choi, P., Henshaw, C., Baker, S., & Tree, J. (2005). Supermum, superwife, supereverything: performing femininity in the transition to motherhood. *Journal of Reproductive and Infant Psychology*, *23*(2), 167-180.

Chaudhary, N., & Bhargava, P. (2006). Mamta: The transformation of meaning in everyday usage. *Contributions to Indian Sociology*, *40*(3), 343-373.

Chaudhary, N., (2015). Mothers and others: the cultural construction of obvious and obscure identities in Cabell, K. R., Marsico, G., Cornejo, C., & Valsiner, J. (Eds.) *Making meaning, making motherhood* (1st ed., pp. 388). Information Age Publishing.

Choudhry, U. K. (1997). Traditional practices of women from India: pregnancy, childbirth, and newborn care. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, *26*(5), 533-539.

Choudhary, S., & Gupta, R. (2020). Culture and borderline personality disorder in India. *Frontiers in Psychology*, *11*, 714.

Dunn, A., Cartwright-Hatton, S., Startup, H., & Papamichail, A. (2020). The parenting experience of those with borderline personality disorder traits: Practitioner and parent perspectives. *Frontiers in Psychology*, *11*, 1913.

Ellison, W. D., Rosenstein, L., Chelminski, I., Dalrymple, K., & Zimmerman, M. (2016). The clinical significance of single features of borderline personality disorder: Anger, affective instability, impulsivity, and chronic emptiness in psychiatric outpatients. *Journal of Personality Disorders, 30(2),* 261-270.

Eyden, J., Winsper, C., Wolke, D., Broome, M. R., & MacCallum, F. (2016). A systematic review ofthe parenting and outcomes

Non-commercial use only

experienced by offspring of mothers with borderline personalitypathology: Potential mechanisms and clinical implications. *Clinical Psychology Review, 47*(2)*,* 85–105.

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.

Fonagy, P., Steele, M., Steele, H., Moran, G. S., & Higgitt, A. C. (1991). The capacity for understanding mental states: The reflective self in parent and child and its significance for security of attachment. *Infant Mental Health Journal, 12*(3), 201-218.

Fornells, M. G., Téstor, C. P., & Baró, M. S. (2018). The Spanish and Catalan versions of the Parent Development Interview-Revised (PDI-R): Adaptation and validation process. *Contemporary Family Therapy*, *40*(4), 338-345.

George, C, Kaplan, N., & Main, M. (1985) The adult attachment interview. *Unpublished manuscript*. University of California at Berkeley.

Hambleton, R. K. (2001). The next generation of the ITC test translation and adaptation guidelines. *European Journal of Psychological Assessment*, *17*(3), 164-172.

Handeland, T. B., Kristiansen, V. R., Lau, B., Håkansson, U., & Øie, M. G. (2019). High degree of uncertain reflective functioning in mothers with substance use disorder. *Addictive Behaviors Reports*, *10*, 100193.

Harkness, S., & Super, C. M. (2002). Culture and parenting. In: Bornstein M.H (ed) *Handbook of parenting*, vol 2. (pp. 253-280). Mahwah, New Jersey: Lawrence Erlbaum Associates.

Kaess, M., Fischer-Waldschmidt, G., Resch, F., & Koenig, J. (2017). Health related quality of life and psychopathological distress in risk taking and self-harming adolescents with full-syndrome, subthreshold and without borderline personality disorder: rethinking the clinical cut-off? *Borderline Personality Disorder and Emotion Dysregulation, 4(1),* 1-12.

Kağitçibasi, Ç. (1996). The autonomous-relational self: A new synthesis. *European Psychologist*, *1*(3), 180.

Keller, H., Bard, K., Morelli, G., Chaudhary, N., Vicedo, M., Rosabal-Coto, M., ... & Gottlieb, A. (2018). The myth of universal sensitive responsiveness: Comment on Mesman *et al*. (2017). *Child Development*, *89*(5), 1921-1928.

Kerr, M. L., Fanning, K. A., Engbretson, A. M., Butitta, K. V., Borelli, J. L., Smiley, P. A., & Rasmussen, H. F. (2022). Fathers' emotional experiences while parenting toddlers: A qualitative exploration. *Early Child Development and Care*, *192*(12), 1982-1997.

Korfine, L., & Hooley, J. M. (2009). Detecting individuals with borderline personality disorder in the community: An ascertainment strategy and comparison with a hospital sample. *Journal of Personality Disorders*, *23*(1), 62-75.

Krueger, R. F., Eaton, N. R., Clark, L. E., Watson, D., Markon, K. E., Derringer, J., Livesley, W. J. (2011). Deriving an empirical structure of personality pathology for DSM-5. *Journal of Personality Disorders*, *25*(2), 170-191.

León, E., Steele, M., Palacios, J., Román, M., & Moreno, C. (2018). Parenting adoptive children: Reflective functioning and parent-child interactions. A comparative, relational and predictive study. *Children and Youth Services Review*, *95*, 352-360.

Loranger, A. W. (1999). *International Personality Disorder Examination: IPDE; DSM-IV and ICD-10; Interviews*. PAR.

McCarthy, K. L., Lewis, K. L., Bourke, M. E., & Grenyer, B. F. (2016). A new intervention for people with borderline personality disorder who are also parents: a pilot study of clinician acceptability. *Borderline Personality Disorder and Emotion Dysregulation*, *3*(1), 1-9.

Mosquera, D., Gonzalez, A., & Leeds, A. M. (2014). Early experience, structural dissociation, and emotional dysregulation in borderline personality disorder: the role of insecure and disorganized attachment. *Borderline Personality Disorder and Emotion Dysregulation, 1(1),*1-8.

Morey, L. (1991). Personality Assessment Inventory professional manual. Odessa, FL: PAR, Inc.

Newman, L., & Stevenson, C. (2005). Parenting and borderline personality disorder: ghosts in the nursery. *Clinical Child Psychology and Psychiatry*, *10*(3), 385-394.

Quek, J., Newman, L. K., Bennett, C., Gordon, M. S., Saeedi, N., & Melvin, G. A. (2017). Reflective function mediates the relationship between emotional maltreatment and borderline pathology in adolescents: A preliminary investigation. *Child Abuse & Neglect*, *72*, 215-226.

Raman, S., Srinivasan, K., Kurpad, A., Dwarkanath, P., Ritchie, J., & Worth, H. (2014). 'My Mother… My Sisters… and My Friends': Sources of maternal support in the perinatal period in urban India. *Midwifery*, *30*(1), 130-137.

Reichenheim, M. E., & Moraes, C. L. (2007). Operationalizing the cross-cultural adaptation of epidemological measurement instruments. *Revista De Saúde Pública*, *41*, 665-673.

Rishede, M. Z., Juul, S., Bo, S., Gondan, M., Bjerrum Møeller, S., & Simonsen, S. (2021). Personality functioning and mentalizing in patients with subthreshold or diagnosed borderline personality disorder: Implications for ICD-11. *Frontiers in Psychiatry*, *12*, 634332.

Roland, A. (1987). The familial self, the individualized self, and the transcendent self: Psychoanalytic reflections on India and America. *Psychoanalytic Review*, *74*(2), 237-250.

Sheehan, D. V. (2014). The M.I.N.I - International Neuropsychiatric Interview, version 7.0 for DSM-5 (MINI 7.0). *Jacksonville, FL: Medical Outcomes Systems*.

Slade, A., Aber, J.L., Berger, B., Bresgi, I., & Kaplan, M. (2003a). The Parent Development Interview – Revised. Unpublished manuscript, City University of New York

Slade, A., Bernbach, E., Grienenberger, J., Wohlgemuth, D., & Locker, A. (2003b). Addendum to reflective functioning scoring manual for use with the Parent Development Interview. New York *(unpublished manuscript)*.

Slade, A., Grienenberger, J., Bernbach, E., Levy, D., & Locker, A. (2005b). Maternal reflective functioning, attachment, and the transmission gap: A preliminary study. *Attachment & Human Development*, *7*(3), 283-298.

Slade, A. (2011). The Pregnancy Interview - Revised (Unpublished manuscript). The City University of New York, New York, NY.

Sleed, M., Slade, A., & Fonagy, P. (2020). Reflective Functioning on the Parent Development Interview: Validity and Reliability in relation to socio-demographic factors. *Attachment & Human Development*, *22*(3), 310-331.

Srinivas, T. (2006). 'As mother made it': The cosmopolitan Indian family, 'authentic' food and the construction of cultural utopia. *International Journal of Sociology of The Family*, *32*(2), 191-221.

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.

Steele, K. R., Townsend, M. L., & Grenyer, B. F. (2019). Parent-

OPEN ACCESS

ing and personality disorder: an overview and meta-synthesis of systematic reviews. *PloS ONE*, *14*(10), e0223038-1-e0223038-26.

Triandis, H. C. (1996). The psychological measurement of cultural syndromes. *American Psychologist*, *51*(4), 407-415.

Trull, T. J., & Widiger, T. A. (1991). The relationship between borderline personality disorder criteria and dysthymia symptoms. *Journal of Psychopathology and Behavioural Assessment*, *13*(2), 91-105.

Tuli, M. (2012). Beliefs on parenting and childhood in India. *Journal of Comparative Family Studies*, *43*(1), 81-91.

Uberoi, P. (1993). Reciprocity in social science: Gender Issues. *The Indian Journal of Social Science*, *6*(3), 243-58.

Vidhatri Raval, V., & Martini, T. S. (2009). Maternal socialization of children's anger, sadness, and physical pain in two communities in Gujarat, India. *International Journal of Behavioral Development*, *33*(3), 215-229.

Wilson, E. O. (1975). *Sociobiology: The New Synthesis*. Cambridge, Massachusetts: Belknap Press of Harvard University Press.

Zalewski, M., Stepp, S. D., Scott, L. N., Whalen, D. J., Beeney, J. F., & Hipwell, A. E. (2014). Maternal borderline personality disorder symptoms and parenting of adolescent daughters. *Journal of Personality Disorders*, *28*(4), 541-554.

Zimmerman, M., Chelminski, I., Young, D., Dalrymple, K., & Martinez, J. (2013). Is dimensional scoring of borderline personality disorder important only for subthreshold levels of severity? *Journal of Personality Disorders*, *27*(2), 244-51.

Non-commercial use only