WILEY | Hindawi

Research Article

Experiences of Women Diagnosed with Borderline Personality Disorder: Perception of Motherhood, Social, Health, and Construction of Gender

Nerea De-la-Morena-Perez,[1] **Inmaculada Corral-Liria** [iD]**,**[2] **Javier Sanchez-Alfonso,**[1]
Ricardo Becerro-de-Bengoa-Vallejo,[3] **Marta Losa-Iglesias,**[2]
and Raquel Jimenez-Fernandez[2]

1Instituto Psiquiátrico José Germain, Leganes, Madrid, Spain
2King Juan Carlos University, Alcorcón, Madrid, Spain
3Complutense University of Madrid, Madrid, Spain

Correspondence should be addressed to Inmaculada Corral-Liria; inmaculada.corral.liria@urjc.es

Purpose. To explore the experiences of women diagnosed with borderline personality disorder (BPD) from a holistic perspective, incorporating their experiences in the social and health fields and their perception of motherhood, and to analyse the influence of the social construction of gender. *Design and Methods*. Qualitative study with a hermeneutic phenomenological design. Eight women with a diagnosis of borderline personality disorder participated in the in-depth interviews. *Findings*. The trauma, stigma, and difficulty associated with motherhood and being a woman are determinants in the experience of symptoms and the recovery from them. *Practical Implications*. The findings offer keys to improving the quality of women's nursing care and the treatment they are provided according to gender factors.

1. Introduction

Borderline personality disorder (BPD) is defined as a pattern of instability in one's social relationships, self-image, and affectivity, and entails marked impulsivity [1, 2]. People diagnosed with BPD are characterized by an intense fear of abandonment, real or imagined [1, 2]. Therefore, they frequently show intense reactions of anger and anguish as well as impulsiveness, self-injurious behaviours, and suicidal behaviours or threats [3]. Their relationships are often very intense and fluctuating [3], and their self-image is characterized by sudden changes in areas such as their values, identity, or desired future [1, 3].

In the childhood histories of people diagnosed with BPD, physical and sexual abuse, carelessness, and early loss of and separation from parents are frequent [2, 4]. It has been observed that a high percentage of people with a diagnosis of

BPD report experiencing severe trauma throughout childhood [5]. Sexual abuse and traumatic childhood experiences are considered as one of the greatest predictors of the development of the disorder [5].

The DSM V estimates the prevalence of BPD among women at 75% [1], although there are diagnostic biases related to gender [2, 6]. The clinical manifestations seem to be more severe and reveal a greater predisposition towards the internalization of symptoms in women than to their externalization in men [7–10]. Therefore, it has been theorized that these manifestations may be related to the extreme representation of characteristic gender traits.

Gender construction is defined as a system of relationships that establishes values and social norms, through which women and men are produced and normalized with respect to the feminine and masculine models (in a heteronormative binary system). Therefore, it encompasses social

attributes, roles, and behaviours, as well as the ideals and subjective components of feminine and masculine identities, which will be transmitted through socialization [11, 12]. Addressing health problems from a gender perspective requires understanding the differences in the socialization of men and women, which determine the different values and behaviours, differences in access to resources, and the sexual division of labour, and that these factors influence both the health of women and men [13]. This makes it possible to detect the risks and problems that they suffer in a particular way, understand the differences in terms of experiences, and identify the most convenient forms of prevention and treatment for women and men. The experiences of people with BPD have been scarcely studied from a gender perspective. Qualitative studies have focused on the experience of women [14–20] and discussed a predominance of negative emotions, experiences of nonexistence, losses of control, and death wishes [14, 15]. The prevalence of traumatic events during childhood is a striking factor related to the feeling of abandonment and rejection during adulthood, as well as the need to be accepted and validated, and to the feelings of shame and guilt towards oneself [16, 21].

Experiences in the health field are marked by apparent discrimination and a lack of understanding by health professionals, especially nurses [19, 20, 22], and by stereotypes associated with a BPD diagnosis [17, 18]. Social relationships are considered essential for recovery [15]. However, people with BPD find it difficult to create and maintain significant and stable relationships due to their own difficulties, the influence of stereotypes [17], and the prevalence of situations of violence and abuse in their environment [17, 23].

Regarding the experience of motherhood, it is a process of special vulnerability due to the stressful changes that it introduces in the lives of mothers, especially in terms of acquiring a new role, changes in the relationship with their partner, and the need to be supported to adapt to the life changes they have to face, as well as the mixed feelings that arise [24]. There are difficulties BPD adds in relation to the parenting process [25–28]. It seems that there is a generational transmission of BPD when learning maternal roles [27]. The high emotional intensity related to this process can also trigger complicated family situations [26], while the difficulty of mentalization makes it more difficult for people with BPD to understand the emotional needs of their children [25]. Women themselves report a high level of anxiety and express their feelings of guilt and concern regarding the impact that their difficulties may have on the development of their children [28].

1.1. Aim. Various studies [7–10, 16] have discussed the disparate clinical presentations of people diagnosed with BPD in relation to gender construction. However, few studies have explored the experiences of people with this disorder by focusing on the weight of social roles in their development and the difficulties these people face.

The difficulty of health professionals, particularly nurses, when providing care to people with BPD, due to the associated stigmas, has been studied [22, 29, 30]; this hinders the provision of quality care. To improve the quality of care provided via nursing, it seems relevant to explore and describe the experiences of women diagnosed with BPD from a holistic perspective, incorporating their perceptions of motherhood and experiences in the social and health fields while analysing the influence of the social construction of gender. This could help nurses to better understand the experiences these women have gone through, the reasons they behave the way they do, and to empathize with them, so that they can better comprehend their care needs and establish a better therapeutic relationship.

2. Methods

2.1. Study Design. The objective is to deepen the understanding of the experiences of women diagnosed with BPD that result from this diagnosis, delving into its impact on their social relationships, on their perception of the health system, and on their motherhood experience, considering the gender construction. A qualitative methodology with a hermeneutic phenomenological design was selected, following the principles of Heidegger [31].

2.2. Setting and Participants. The participants were women over 18 years of age diagnosed with BPD, who had been under treatment in HUJG for more than one year after their diagnosis, to ensure that they could clearly discuss their own experiences afterwards. For recruitment, professionals from different units of HUJG were informed by the main researcher about the criteria and objectives of the study, and they proposed possible informants based on them. Women were approached by their referral therapist, who explained to them the possibility of participating in the research; those women who agreed to be contacted were approached by the researchers through telephone to provide them with the information regarding the investigation and to make an appointment for the interview in case they finally agreed. None of them refused to participate. Any women who might have difficulty in understanding or speaking Spanish and those who presented clinical symptoms at the time of the research that prevented or discouraged their participation were excluded. Convenience sampling was performed; later, according to our analysis of the data, we applied a theoretical sampling by taking into account the profiles of interest based on the information needs we had detected, to ensure maximum discourse variability [32]. The sample size was determined using the data saturation principle [32], resulting in a total of 8 women.

2.3. Data Collection. Data collection was carried out at the José Germain University Hospital (HUJG), between September 2020 and November 2021. In-depth, semistructured, and individual interviews were carried out with a script of open-ended questions, detailed in Table 1, each lasting between 45 and 90 minutes [32]. They were recorded with audio support with the consent of the participants.

During this study, the health crisis due to COVID-19 began; thus, some interviews were conducted through the

Table 1: Script of open-ended questions made in the individual interviews.

Script of open-ended questions made in the individual interviews
What has the diagnosis of borderline personality disorder meant for you? How would you explain what it means to have this disorder?
How would you describe the care received by health professionals? Have you observed differences in care between different services? And between the different professional categories (doctors, nurses, nursing assistants...)?
How would you describe your relationship with your family? And with other people? How would you describe the support received by the people closest to you?
In what way do you think your diagnosis may have influenced your personal and family relationships?
In what way do you think your diagnosis or symptoms may influence the way you are perceived socially?
If you have children, how have the difficulties of your problem influenced the care of your children? How do you think your diagnosis and treatment process may have influenced them?
How would you describe your life experiences to date? What are the experiences that have marked you the most?

virtual videoconferencing platform Jitsi [33]. Other interviews were conducted in person while respecting the sanitary measures imposed by the Ministry of Health [34]. A room in HUJG was chosen that allowed adequate sanitary and privacy conditions [32], where only the interviewee and interviewer were present. The interviews were conducted by the main researcher and supervised by other researchers of the team, who had extensive previous experience in conducting in-depth interviews.

2.4. Data Analysis. Thematic analysis was performed following Smith et al. [35]. The interviews were transcribed in their entirety, and then reading, coding, and categorization were carried out, which allowed the generation of a framework of relevant meanings. The computer software NVivo was used.

To ensure the rigor and quality of the results, the COREQ criteria were taken into account [36]. Validity and credibility were used as rigor criteria, making the transcriptions of the women's experiences and using the generated verbatim to carry out the interpretative analysis. To determine this credibility, triangulation of the data was also increased with an external researcher, an expert in qualitative research, who was invited to a presentation session. The results were also contrasted with the literature. In the same way, the analysis was verified with several informants, which ensured greater credibility via this feedback [32].

This study meets the transferability criterion because an exhaustive description of the entire context and participants has been made; therefore, the results obtained can be transferred to groups with similar characteristics. In the same way, complete data collection has been used, making the verbatim give dependability to this study. Finally, the research team has acquired a commitment by reporting its position in the work, showing its confirmability [37].

2.5. Ethics. The following basic legal and bioethical principles of research were taken into account: beneficence, nonmaleficence, justice, and autonomy [38]. This study was approved by the Directorate of HUJG and by the Clinical Research Ethics Committee (CEIC) of Severo Ochoa University Hospital (Minute 03/20 (25/03/2020)). The participants were informed of the study and their ARCO rights, and their voluntary signing of informed consent was requested for their participation and the recording of their interviews, guaranteeing the possibility for revocation. Confidentiality was ensured through coding, and accessibility was guaranteed to be granted only to the principal investigator.

3. Results

3.1. Patients: Sociodemographic Characteristics. Eight women with an average age of 43 years and an average mental health follow-up time of 9.6 years participated in the research. All of them had been admitted to a brief psychiatric hospitalization unit at least once. In addition, 7 of the 8 participants had children. The characteristics of the sample are detailed in Table 2.

3.2. Analysis of Thematic Content in the Discourses. The results obtained from the analysis of the discourses of the participating women have been organized into thematic areas with corresponding subtopics according to the revealed meanings, as shown in Tables 3 and 4.

3.2.1. Fatal Childhood, Fatal Teenagerhood. There is a great emotional instability that began in childhood, with feelings of sadness and loneliness being predominant. The presence of devastating events in the immediate environment is characteristic. In some cases, follow-up via mental health services begins at this time, as a consequence of emotional and behavioural problems.
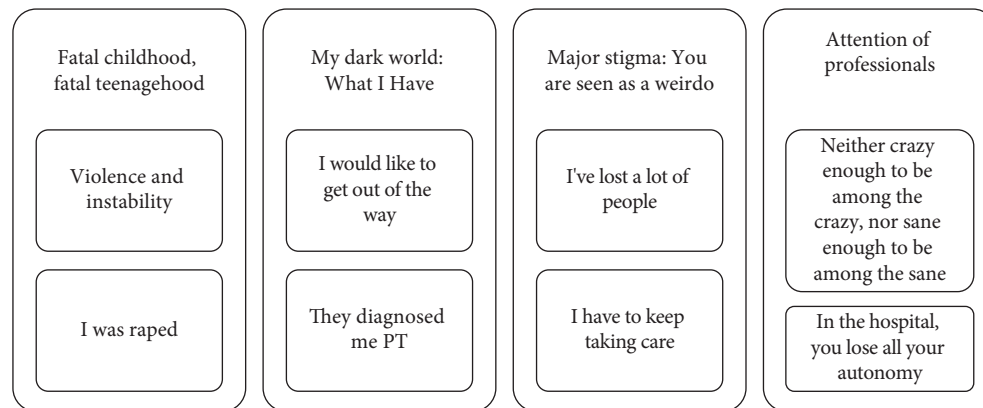
The informants related their current suffering to experiences suffered in childhood. The expression of insecurity and fear within the family is common, with parents defined as unstable, unpredictable, and even violent, verbally or physically. In several interviews, experiences of sexual abuse by close relations, sometimes family members, were mentioned. The informants themselves consider these facts as important triggers of their symptoms of the disorder.

3.2.2. My Dark World: What I Have. Feelings of sadness, depression, and emotional instability predominate, which produces limitations in day-to-day life. Sometimes, these are related to the withdrawal of important people or the perception of a lack of help. In addition, they are described as the reason informants interpret reality in a disproportionate way—manifesting extreme ideas in relation to the events involving or intentions of others. Their consequent impulsive reactions are described as one of their main difficulties, as they pose a problem when creating and maintaining relationships.

TABLE 2: Participant sociodemographic characteristics.

Code	Age	Marital status	Children	Employment situation	Educational level	Follow-up in another resource	Follow-up time in MS
M01	55	Separated	2	Disabled	Secondary	Day hospital	6 years
M02	47	Separated	1	Disabled	Primary	Day hospital	7 years
M03	47	Married	2	Work leave	University	Day hospital	5 years
M04	44	Married	1	Unemployment	Primary	Day hospital	3 years
M05	40	Separated	2	Housewife	Professional training	Hospital rehabilitation unit	15 years
M06	47	Married	—	Unemployment	Secondary	—	10 years
M07	52	Married	3	Disabled	Professional training	—	20 years
M08	23	Single	—	Unemployment	Secondary	—	11 years

TABLE 3: Topics and subtopics found.

Fatal childhood, fatal teenagehood	My dark world: What I Have	Major stigma: You are seen as a weirdo	Attention of professionals
Violence and instability	I would like to get out of the way	I've lost a lot of people	Neither crazy enough to be among the crazy, nor sane enough to be among the sane
I was raped	They diagnosed me PT	I have to keep taking care	In the hospital, you lose all your autonomy

Emphasis is placed on the loss of control of one's own actions in situations of high emotional burden and the ability to cause harm in those moments, both to other people and themselves. Aggression manifests itself verbally or even physically in the form of an attack or self-harm. They consider these reactions both "abnormal" and inevitable at the time of a crisis. Sometimes, there is regret, or even fear of oneself or one's own reactions. In other cases, there is no regret because there is no clear memory of what happened.

On the other hand, there is the discussion of suffering experienced throughout life and the inability to enjoy experiences, as well as of the insecurities and fears that increase with the development of BPD symptoms. Ideas of death are frequent, recurrent, and ongoing, together with autolytic gestures of varying severity. Frustration is sometimes expressed as the inability to commit suicide. In general, these ideas increase in moments of greater crisis and suffering.

Regarding their experience with the BPD diagnosis, in general, this is perceived to be an imposed label with which they do not identify. For some women, it cannot effectively explain what happens to them; they consider it too nonspecific. Others do not believe that their problem is part of the disorder since they do not feel sick. Rather, they relate this label to the stereotypes that are socially attributed to it, associating it with immature or capricious people, which produces their rejection of a diagnosis they deem stigmatizing.

3.2.3. Large Stigma: You Are Seen as a Weirdo. Social and family relationships, from which they do not receive the support they need, are considered scarce. There is a perception of distancing, especially when there are episodes of crisis or self-harm. Reference is made to their experience of emptiness, related to their feeling of abandonment and lack of social support.

The informants perceive a dichotomy regarding social stereotypes, since they feel that they are not only treated as "crazy" or "weird"—incapable of making important decisions—but also expected to function normally, especially with regard to the care of children and the home. Therefore, these women believe that it is important for professionals to provide adequate information to their support team to ensure they can help them in the recovery process.

Few informants have support from other people. They highlight their presence throughout the experience with the disease, their proportion of affection, and the fact that they have not abandoned them. Feelings of guilt arise in relation to those whom they consider they have hurt, since they think that abandonment is the norm.

Some informants shared their experiences as primary caregivers. Often, they are the only ones responsible for the care of their children or parents, which makes it difficult to attend psychotherapeutic treatment. They mention the questioning of some professionals regarding their participation in treatment due to the frequent absences driven by their care tasks, which they interpret as punishment, despite the effort they have put into treatment.

TABLE 4: Text fragments of the interviews of the participants.

Subtopics	Textual fragments
Violence and instability	M01: "And all this comes because I have suffered a lot since I was little, I have had many problems since I was little with. . . My parents."
	M04: "My mother, when she got up badly, would get angry and hit you. I haven't received a kiss from my parents or a hug. . . (pause). It's been very hard."
	M07: "When I said at the age of 16 that I had a drug problem, my father threw me out of the house. My parents almost separated because of me."
I was raped	M07: "There is an issue, but it's not. . . it's very hard. . . it's really hard (. . .). I'm just going to tell you that I was raped."
	M01: "My brother abused me. . . I don't talk to that one. . . We were in my father's office, we had gone to do our homework (long silence). I hardly talk about this."
	M08: "A violation. From a supposed friend of mine. With 12 years. She hit me and everything, and I lied in the complaint because she had threatened me with death. (. . .) That was when I got worse. They gave me seizures, they had to tie me up, sedate me. . . I got into drugs. . . Everything. These are things that I don't usually share." (M08)
I would like to get out of the way	M08: "When I was 11 years old, I tried to commit suicide, and. . . I have already taken 6 or 7 attempts."
	M04: "My brother committed suicide because of the situation of my house, which was not pleasant. And he was brave and committed suicide. And I've tried 5 times and I'm still here."
	M06: "The day I think about the pills, he can hide all the pills he wants, that as long as I say I take them, I take them. At my mother's house I have also tried, but she caught me, because I vomited blood; then she caught me and I had to tell her."
They diagnosed me PT	M03: "I am not very satisfied. I want an explanation of why I have this psychic suffering since I can remember, almost."
	M02: "It's like they put something there and that's it, but I'm not interested in knowing what symptoms it has, because I think that when you start to find out what the symptoms are like, and what the disorder is like, it can be good, but also it can be very negative, in the sense that it stigmatizes you."
	M02: "And that the diagnosis, well, that's it, a label, huh? But it's not you, you're not "borderline personality disorder," you can have borderline personality disorder, but that's not you."
I have lost many people	M04: "Well, they turn away from you. If you already have a mental illness they say "wow, this one has a mental illness", and they turn away from you. They do not want anyone with mental illness."
	M01: "I have no one here. I have a brother who is working a lot and he cannot accompany me; my sister-in-law, when I have fallen ill, she has put me aside; the family has cast me aside."
	M03: "I have lost people along the way, because when I have directly hurt myself they have disappeared from my life because they did not want to know anything about someone like that."

TABLE 4: Continued.

Subtopics	Textual fragments
	M07: "My children have had a very bad time, very bad, and I feel very guilty. That is there for my whole life."
I have to continue caring	M03: "My psychiatrist told me "you have to get discharged," and I told him "you haven't seen me for 4 months, how are you going to discharge me?." And he tells me "yes, because you are missing a lot, you are taking care of your children, and your parents. . . ." And I told him, "you are punishing me for being a mother, you are punishing me for taking care of my parents."
	M04: "Sometimes I also hit my son, I yell at him, and I do things that my parents did to me too."
	M03: "I have the feeling that professionals sometimes do not take me seriously, because it is true that my pathology, or my attitude, is not as evident as that of other people with mental illnesses. So it does give me the feeling that they have criteria, and they leave me a little apart."
	M03: "When I have to go back, they put a different label on me. If I go with this label, maybe they treat me based on this label and they don't know how to help me, or they can't help me."
Neither crazy enough to be among the crazy, nor sane enough to be among the same	M02: "The other time I was in the day hospital. . .uh. . .I think I didn't fit in at all. And this one time I haven't come to fit in either, I always have the feeling that, once again, I don't fit in. That I'm not crazy enough to be among the insane, but I'm not sane enough to be among the sane either."
	M02: "Fatal, we always finished. . .something always happened and it ended badly. Because they order you in a way. . .It appears to be you are stupid. In addition, then the medications, overmedicated. They tied me up. . ."
In the hospital, you lose your autonomy	M06: "Being treated worse than a dog. . .I think that's shameful, too shameful."
	M02: "I had a bad episode, and they took me there involuntarily. And it made me feel like a prisoner, like a prisoner. I understand them perfectly and I appreciate them, the prisoners, because. . . That's the worst thing that can happen to you."

Feelings of guilt and suffering are frequent due to the inability to dedicate the time or effort they consider necessary for such care, either due to their psychopathological situation or the occasional need to delegate this care to others. Their guilt is greater when their children have witnessed crises or have been victims of their manifestations of aggression—frequently triggered by family conflicts with high emotional burden. They consider support essential to perform care tasks, especially in periods of instability, since they are unable to adequately carry out this role alone.

On the other hand, their family and children are mentioned as one of the main reasons they do not perform more autolytic gestures, or they continue to struggle to maintain stability. Sometimes, their children themselves have become the caregivers of the informants.

3.2.4. Attention of Professionals. The informants' experiences with health professionals seem generally good. They value the feeling that they have been given real attention, understanding, a sense of connection, and the security of being able to request professional help if they are in a crisis situation, as well as the perception that "everything is done for them." Interventions based on the prescription of psychopharmacological treatment are perceived to be insufficient. In general, these lack closer proximity and a more personalized treatment.

On the other hand, they consider that their treatment is different from that for people with other mental health problems, referring to a stigma associated with the diagnosis of BPD. They appreciate a treatment that is not focused on this diagnostic label but on their own needs, making them feel more empowered in the process.

The experiences in hospitalization units are generally negative among women with greater behavioural problems; they mention having been treated "like fools" or "like dogs." In addition, there is the discussion of theexcessive use of psychotropic drugs and mechanical restraints as attempts to resolve crisis situations, which they interpret as punishment. They describe the sensation of feeling as "prey" in these units due to their closed and routine structure, with excessive norms that they consider extreme and even violate their privacy, whereby they feel that they lose their autonomy. This leads to them not asking for help in crisis situations for fear of punishment. Regarding the ways to improve this experience, they suggest that there should be greater closeness, with less treatment based on surveillance, and they believe it is important to develop new intervention tools for professionals with an approach to crisis situations that allows a perception of help and care.

4. Discussion

Early attachment problems are considered one of the main factors in the development of BPD [39]. Among the women participating in this study, their memories of childhood and adolescence are impregnated with negative emotions, such as fear, loneliness, or sadness. These expressions arise from experiences in their family environment in narrations of violent events, rejection and abandonment, insecurity and instability of the home itself, and a sense of a lack of care and expressions of affection. According to Fonagy [40], 92% of people with BPD have an insecure attachment style, characterized by inconsistency in parental care. In addition, numerous studies [4, 21, 41, 42] have found a very significant relationship between experiences of parental abuse and neglect in childhood and the symptoms of BPD. Reports of sexual abuse during the childhoods and adolescence of the participants should also be noted. Such abuse has been described as one of the main predictors of the development of BPD [39, 43].

It is interesting that trauma is not one of the diagnostic criteria for BPD in the DSM [1]. Therefore, its use as a way to deny the importance of abuse, trauma, and oppression in psychological distress has been discussed [44], especially when it is suffered by women. We must take into account the relationship between trauma and gender and the violence exercised against women as a result of the power relations in their family environment, community, and institutions themselves [43, 45]. In addition, abuse in childhood and adolescence seems to have different consequences according to the sex of its victims, with more internalization problems such as depression, anxiety, and isolation in women according to a recent report on child abuse in the family in Spain [46], which could lead to different diagnoses in adulthood in similar trauma situations [6].

Regarding the most problematic revealed difficulties, the informants highlighted emotional and behavioural instability. These results coincide with those in previous studies [21, 39, 47, 48] where the inability to tolerate negative emotions has been explored; specifically, they resort to maladaptive coping mechanisms, such as self-harm or self-harm attempts [48]. Self-destructive behaviours are repeatedly mentioned in the discourses of the informants in this study. Self-injurious behaviours often result from impulsive behaviour due to the inability to handle intense negative emotions [21, 39, 47], serving as an attempt to regain control and change an experience from emotional pain to physical pain, which is easier to bear [39]. According to various studies [45, 49, 50], self-harm with BPD is more frequent among women due to their greater tendency to act via self-harm. In contrast, in autolytic attempts, with the same frequency between sexes, lethality among men is higher due to the means that are used.

In moments of emotional crisis, dissociative experiences are narrated with a lack of awareness of what is happening; this phenomenon has also been frequently described in the literature [39, 50] as a consequence of early trauma and as a way of dealing with situations that one cannot effectively address.

Regarding their experience with their diagnosis, the participants defined it as an external imposition with which they do not identify. According to Lamont and Dickens [51], this is the case for a large proportion of people diagnosed with BPD; however, for some of them, their diagnosis provides relief and a sense of control and hope [39, 52]. With

respect to the imposition of this diagnosis, Chesler [53] and other authors [44, 54] notably mention a pathologization of female traits through diagnoses such as BPD—an argument that agrees with that of Caroll Gilligan [53] in relation to gender biases in science.

With respect to their social and family relationships, the informants reported a great scarcity of them and their perception of abandonment and rejection, usually due to the appreciation of their symptoms. This is consistent with various studies [17, 21, 55, 56] that also mention a greater predisposition of people diagnosed with BPD towards re-membering social situations with a negative connotation [55] and a lower capacity to enjoy them [56]. Moreover, the importance of social relationships in the recovery process has been highlighted by numerous studies [15, 39, 57–60].

Notably, the experiences of stigma among the partici-pants comprise both treatments based on stereotypes and normalizations of their suffering. This dichotomy has been described in other articles [17, 61], which have also revealed a greater stigmatization of BPD than other disorders due to social incomprehension of its manifestations. This nor-malization of suffering has been associated with social ste-reotypes imposed on the female condition in relation to frailty and care-seeking; this theory relates to the ideas on exclusive binary representations proposed by Soley-Beltran [62].

Regarding the relevant care tasks, our results agree with the literature [25–27, 43, 63] in which barriers to the access of treatment by women with dependents are exposed, particularly the lack of consideration by health professionals in this situation. Studies mention difficulties exercising the role of mother in periods of instability, which produces guilt, suffering, and a feeling of incapacity—emotions closely linked to the mandates imposed on mothers [63]. Such experiences are articulated in Bartsch et al. [63], e.g., diffi-culties maintaining a stable environment for children, and in Dunn et al. [26], e.g., struggles recognizing the emotions of children and responding proportionally. In addition, mo-ments when children become caregivers, as well as when overprotective behaviours are performed in compensation, are highlighted [26, 63]. It seems necessary to consider the adaptation of health services to the profile of users who perform care tasks to prevent marginalization via resources, and on the other hand, to carry out interventions that take into account the role of motherhood, fostering improved coping and the acquisition of parenting skills, to help prevent the generational transmission of mental health problems [25–27, 63].

On the other hand, their experiences with health pro-fessionals were described by the informants as marked by stigma, distance, and even trauma when in hospitalization units. The stigma of professionals towards BPD has been widely described [51, 52, 57, 61, 64], as has the negative consequences associated with the quality of care [52]. Re-garding hospital units, other studies [51, 64] agree with our findings, i.e., they provide a more negative experience than other types of services due to greater medicalization of the process and excessive rigidity and paternalism, in addition to, as expressed by the informants, the need for greater training of professionals in terms of patients' problems and listening and comprehension skills. Previous research [52, 59, 64] has similarly recommended facilitating the understanding of the suffering of people with a diagnosis of BPD through the transmission of their experiences in their own voice.

5. Conclusions

The childhood experiences of the informants have been marked by a series of traumatic events that influence the development of their disorder and suffering in adulthood. During the maturity of these women, the predominant feelings are negative. In addition, impulsive reactions are a main problem for them; they make it difficult to maintain a satisfactory life. Social and family relationships are marked by this type of reaction, the presence of stigma, and the underestimation of suffering. Relationships with health professionals are affected by this stigma, especially in the hospital environment.

Informants' motherhood and parenting are marked by their difficulties with this process itself, which cause guilt, suffering, and the feeling of inability to exercise the role of mother. Care by health professionals during these processes is scarce.

In all these areas, to properly understand the experiences and traumas experienced throughout the life of these women, the stereotypes and social norms imposed on them must be considered.

5.1. Implications for Nursing Practice. The present study allows nurses to better understand the care needs among women with BPD. We must consider the need to incorporate families into the illness and recovery process to improve the understanding of the needs of these women, since this factor could affect their recuperation. In addition, we must be aware of the requirements and difficulties of such women who exercise a caregiving role, of the need to adapt services to these needs, and of paying attention to the process of motherhood in our interventions.

On the other hand, the improved understanding of the first-person suffering of women with BPD—through studies such as this one—could help reduce the associated stigma, and in this way, improve the quality of care provided to these women.

Data Availability

The data set used and analysed during the current study is available from the corresponding author upon reasonable request.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

Authors' Contributions

Nerea De-la-Morena-Pérez, Inmaculada Corral-Liria, and Raquel Jiménez-Fernandez were involved in the design of

the study. Nerea De-la-Morena-Pérez collected the data for the study. Inmaculada Corral-Liria, Javier Sánchez-Alfonso, and Ricardo Becerro-de-Bengoa-Vallejo undertook the background literature search. Marta Losa-Iglesias, Nerea De-la-Morena-Pérez, and Raquel Jiménez-Fernandez undertook the data analysis and drafted initial versions of the paper. All the authors made substantive contributions to the final submitted paper.

References

[1] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Text Revision (DSM-5-TR)*, American Psychiatric Association, Arlington, VA, USA, 5th edition, 2022.

[2] J. G. Gunderson, I. Weinberg, and L. Choi-Kain, "Trastorno límite de la Personalidad," in *Trastornos de la Personalidad (I)*, J. M. Oldham, J. C. Fowler, D. J. Hales, and M. H. Rapaport, Eds., pp. 15–33, Focus, Arlington, TX, USA, 2013.

[3] L. Sperry, *Handbook of Diagnosis and Treatment of DSM-5 Personality Disorders*, Rouledge, New York, NY, USA, 3th edition, 2016.

[4] L. I. Reed, G. Fitzmaurice, and M. C. Zanarini, "The relationship between childhood adversity and dysphoric inner states among borderline patients followed prospectively for 10 years," *Journal of Personality Disorders*, vol. 29, no. 3, pp. 408–417, 2015.

[5] S. Tschoeke, D. Bichescu-Burian, T. Steinert, and E. Flammer, "History of childhood trauma and association with borderline and dissociative features," *The Journal of Nervous and Mental Disease*, vol. 209, no. 2, pp. 137–143, 2021.

[6] L. C. Morey, G. M. Alexander, and C. Boggs, "Género," in *Tratado de los trastornos de la personalidad*, J. M. Oldham, Ed., pp. 543–561, Masson, Barcelona, Spain, 2007.

[7] A. Silberschmidt, S. Lee, M. Zanarini, and S. C. Schulz, "Gender differences in borderline personality disorder: results from a multinational, clinical trial sample," *Journal of Personality Disorders*, vol. 29, no. 6, pp. 828–838, 2015.

[8] A. Banzhaf, K. Ritter, A. Merkl, O. Schulte-Herbrüggen, C. H. Lammers, and S. Roepke, "Gender differences in a clinical sample of patients with borderline personality disorder," *Journal of Personality Disorders*, vol. 26, no. 3, pp. 1–13, 2012.

[9] N. Hoertel, H. Peyre, M. M. Wall, F. Limosin, and C. Blanco, "Examining sex differences in DSM-IV borderline personality disorder symptom expression using Item Response Theory (IRT)," *Journal of Psychiatric Research*, vol. 59, pp. 213–219, 2014.

[10] R. A. Sansone and L. A. Sansone, "Gender patterns in borderline personality disorder," *Innovations in Clinical Neuroscience*, vol. 8, no. 5, pp. 16–20, 2011.

[11] N. Krieger, "Glosario de Epidemiología social," *Revista Panamericana de Salud Públic*, vol. 11, no. 5–6, pp. 480–490, 2002.

[12] J. Butler, *Undoing Gender*, Paidós, Barcelona, Spain, 1st edition, 2004.

[13] C. Borrell and L. Artazcoz, "Las desigualdades de género en salud: retos para el futuro," *Revista Española de Salud Pública*, vol. 82, no. 3, pp. 245–249, 2008.

[14] G. Dammann, C. Hügli, J. Selinger et al., "The self-image in Borderline Personality Disorder: an in-depth qualitative research study," *Journal of Personality Disorders*, vol. 25, no. 4, pp. 517–527, 2011.

[15] G. Black, J. Murray, and G. Thornicroft, "Understanding the phenomenology of borderline personality disorder from the patient's perspective," *Journal of Mental Health*, vol. 23, no. 2, pp. 78–82, 2014.

[16] A. L. Holm, A. Berg, and E. Severinsson, "Longing for reconciliation: a challenge for women with borderline personality disorder," *Issues in Mental Health Nursing*, vol. 30, no. 9, pp. 560–568, 2009.

[17] O. Bonnington and D. Rose, "Exploring stigmatisation among people diagnosed with either bipolar disorder or borderline personality disorder: a critical realist analysis," *Social Science & Medicine*, vol. 123, pp. 7–17, 2014.

[18] T. Walker, "Seeing beyond the battled body": an insight into selfhood and identity from women's accounts who self-harm with a diagnosis of borderline personality disorder," *Counselling and Psychotherapy Research*, vol. 9, no. 2, pp. 122–128, 2009.

[19] A. L. Holm and E. Severinsson, "Struggling to recover by changing suicidal behaviour: narratives from women with borderline personality disorder," *International Journal of Mental Health Nursing*, vol. 20, no. 3, pp. 165–173, 2011.

[20] S. Lawn and J. Mcmahon, "Experiences of care by Australians with a diagnosis of borderline personality disorder," *Journal of Psychiatric and Mental Health Nursing*, vol. 22, no. 7, pp. 510–521, 2015.

[21] N. Ntshingila, M. Poggenpoel, C. P. H. Myburgh, and A. Temane, "Experiences of women living with borderline personality disorder," *Health SA Gesondheid*, vol. 21, pp. 110–119, 2016.

[22] G. Dickens, E. Lamont, and S. Gray, "Mental health nurses' attitudes, behaviour, experience and knowledge regarding adults with a diagnosis of borderline personality disorder: systematic, integrative literature review," *Journal of Clinical Nursing*, vol. 25, no. 13–14, pp. 1848–1875, 2016.

[23] E. Rivera-Segarra, G. Rivera, R. Lopez-Soto, G. Crespo-Ramos, and D. Marques-Reyes, "Stigmatization experiences among people living with Borderline Personality Disorder in Puerto Rico," *Qualitative Report*, vol. 19, no. 30, pp. 1–18, 2014.

[24] S. Berlanga Fernández, M. F. Vizcaya-Moreno, and R. M. Pérez-Cañaveras, "Percepción de la transición a la maternidad: estudio fenomenológico en la provincia de Barcelona," *Atención Primaria*, vol. 45, no. 8, pp. 409–417, 2013.

[25] K. R. Steele, M. L. Townsend, and B. F. S. Grenyer, "Parenting stress and competence in borderline personality disorder is associated with mental health, trauma history, attachment and reflective capacity," *Borderline Personality Disorder and Emotion Dysregulation*, vol. 7, no. 1, p. 8, 2020.

[26] A. Dunn, S. Cartwright-Hatton, H. Startup, and A. Papamichail, "The parenting experience of those with borderline personality disorder traits: practitioner and parent perspectives," *Frontiers in Psychology*, vol. 11, p. 1913, 2020.

[27] K. R. Steele, M. L. Townsend, and B. F. S. Grenyer, "Parenting and personality disorder: an overview and meta-synthesis of systematic reviews," *PLoS One*, vol. 14, no. 10, Article ID e0223038, 2019.

[28] M. Zalewski, S. D. Stepp, D. J. Whalen, and L. N. Scott, "A qualitative assessment of the parenting challenges and treatment needs of mothers with borderline personality disorder," *Journal of Psychotherapy Integration*, vol. 25, no. 2, pp. 71–89, 2015.

[29] E. Bodner, S. Cohen-Fridel, M. Mashiah et al., "The attitudes of psychiatric hospital staff toward hospitalization and treatment of patients with borderline personality disorder," *BMC Psychiatry*, vol. 15, no. 1, p. 2, 2015.

[30] L. Westwood and J. Baker, "Attitudes and perceptions of mental health nurses towards borderline personality disorder clients in acute mental health settings: a review of the

literature," *Journal of Psychiatric and Mental Health Nursing*, vol. 17, no. 7, pp. 657–662, 2010.

[31] A. Wilson, "Being a practitioner: an application of Heidegger's phenomenology," *Nurse Researcher*, vol. 21, no. 6, pp. 28–33, 2014.

[32] K. D. Norman and S. L. Yvonna, *The SAGE Handbook of Qualitative Research*, Sage, London, UK, 5th edition, 2018.

[33] Jitsi, "8x8 Incs Jitsi," 2020, https://jitsi.org/about/.

[34] Ministerio de Sanidad Consumo y Bienestar Social and G. de España, "Cuatro claves para protegerse de la COVID-19," 2020, https://www.mscbs.gob.es/profesionales/saludPublica/ccayes/alertasActual/nCov/documentos/COVID19_4_claves.pdf.

[35] J. A. Smith, P. Flower, and M. Larkin, *Interpretative Phenomenological Analysis: Theory, Method and Research*, Sage, Londres, UK, 2009.

[36] A. Tong, P. Sainsbury, and J. Craig, "Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups," *International Journal for Quality in Health Care*, vol. 19, no. 6, pp. 349–357, 2007.

[37] H. Nguyen, J. Ahn, A. Belgrave et al., "Establishing trustworthiness through algorithmic approaches to qualitative research," *Communications in Computer and Information Science*, vol. 1312, pp. 47–61, 2021.

[38] B. Varkey, "Principles of clinical Ethics and their application to practice," *Medical Principles and Practice*, vol. 30, no. 1, pp. 17–28, 2021.

[39] D. Mosquera, A. Gonzalez, and A. M. Leeds, "Early experience, structural dissociation, and emotional dysregulation in borderline personality disorder: the role of insecure and disorganized attachment," *Borderline Personality Disorder and Emotion Dysregulation*, vol. 1, no. 1, p. 15, 2014.

[40] P. Fonagy, "Attachment and borderline personality disorder," *Journal of the American Psychoanalytic Association*, vol. 48, no. 4, pp. 1129–1146, 2000, http://journals.sagepub.com/doi/10.1177/00030651000480040701.

[41] E. J. Levey, G. Apter, and A. M. Harrison, "The global problem of child maltreatment: perspectives on mechanisms of influence and illness presentation," *International Journal of Culture and Mental Health*, vol. 10, no. 1, pp. 90–96, 2017.

[42] C. Winsper, J. Hall, V. Y. Strauss, and D. Wolke, "Aetiological pathways to Borderline Personality Disorder symptoms in early adolescence: childhood dysregulated behaviour, maladaptive parenting and bully victimisation," *Borderline Personality Disorder and Emotion Dysregulation*, vol. 4, no. 1, p. 10, 2017.

[43] M. Ruiz and M. C. Vairo, "Borderline Personality Disorder. Kingdom of women, land without men," *Vertex*, vol. 19, no. 81, pp. 303–308, 2008.

[44] C. Shaw and G. Proctor, "I. Women at the margins: a critique of the diagnosis of borderline personality disorder," *Feminism & Psychology*, vol. 15, no. 4, pp. 483–490, 2005.

[45] J. E. Lambert, *Women's Narratives of Their Experiences with the Diagnosis of Borderline Personality Disorder (BPD)*, Georgia State University, Atlanta, GA, USA, 2018.

[46] C. Reina Sofía, "Maltrato Infantil en la familia en España," 2011, https://observatoriodelainfancia.mdsocialesa2030.gob.es/productos/pdf/malt2011v4_total_100_acces.pdf.

[47] C. Chu, S. E. Victor, and E. D. Klonsky, "Characterizing positive and negative emotional experiences in young adults with Borderline Personality Disorder symptoms," *Journal of Clinical Psychology*, vol. 72, no. 9, pp. 956–965, 2016.

[48] E. Svoboda, "Kings and queens of chaos," *Psychology Today*, vol. 7, pp. 80–87, 2013.

[49] L. Sher, S. B. Rutter, A. S. New, L. J. Siever, and E. A. Hazlett, "Gender differences and similarities in aggression, suicidal behaviour, and psychiatric comorbidity in borderline personality disorder," *Acta Psychiatrica Scandinavica*, vol. 139, no. 2, pp. 145–153, 2019.

[50] M. C. Zanarini, C. S. Laudate, F. R. Frankenburg, B. Reich, and G. Fitzmaurice, "Predictors of self-mutilation in patients with Borderline Personality Disorder: a 10 year follow-up study," *Journal of Psychiatric Research*, vol. 45, no. 6, pp. 823–828, 2011.

[51] E. Lamont and G. L. Dickens, "Mental health services, care provision, and professional support for people diagnosed with borderline personality disorder: systematic review of service-user, family, and carer perspectives," *Journal of Mental Health*, vol. 30, no. 5, pp. 619–633, 2019.

[52] D. Ring and S. Lawn, "Stigma perpetuation at the interface of mental health care: a review to compare patient and clinician perspectives of stigma and borderline personality disorder," *Journal of Mental Health*, vol. 12, pp. 1–21, 2019.

[53] P. Chesler, *Women and Madness*, Four walls, eight windows, New York, NY, USA, 1997.

[54] J. Wirth-Cauchon, "Women on the borders. Feminine instability," in *Women and Borderline Personality Disorder: Symptoms and Stories*, pp. 79–118, Rutgers University Press, New York, NY, USA, 2001.

[55] J. Botsford and B. Renneberg, "Autobiographical memories of interpersonal trust in borderline personality disorder," *Borderline Personality Disorder and Emotion Dysregulation*, vol. 7, no. 1, pp. 14–10, 2020.

[56] L. Liebke, G. Koppe, M. Bungert et al., "Difficulties with being socially accepted: an experimental study in borderline personality disorder," *Journal of Abnormal Psychology*, vol. 127, no. 7, pp. 670–682, 2018.

[57] A. Carmel, N. I. Torres, S. Chalker, and K. A. Comtois, "Interpersonal barriers to recovery from borderline personality disorder: a qualitative analysis of patient perspectives," *Personality and Mental Health*, vol. 12, no. 1, pp. 38–48, 2018.

[58] F. Y. Y. Ng, M. L. Townsend, C. E. Miller, M. Jewell, and B. F. S. Grenyer, "The lived experience of recovery in borderline personality disorder: a qualitative study," *Borderline Personality Disorder and Emotion Dysregulation*, vol. 6, no. 1, pp. 10–19, 2019.

[59] C. Katsakou and N. Pistrang, "Clients' experiences of treatment and recovery in borderline personality disorder: a meta-synthesis of qualitative studies," *Psychotherapy Research*, vol. 28, no. 6, pp. 940–957, 2018.

[60] A. Shepherd, C. Sanders, M. Doyle, and J. Shaw, "Personal recovery in personality disorder: systematic review and meta-synthesis of qualitative methods studies," *International Journal of Social Psychiatry*, vol. 62, no. 1, pp. 41–50, 2015.

[61] L. Sheehan, K. Nieweglowski, and P. Corrigan, "The stigma of personality disorders," *Current Psychiatry Reports*, vol. 18, no. 1, pp. 11–17, 2016.

[62] P. Soley-Beltran, "Modelling femininity," *European Journal of Women's Studies*, vol. 11, no. 3, pp. 309–326, 2004.

[63] D. R. Bartsch, R. M. Roberts, M. Davies, and M. Proeve, "Understanding the experience of parents with a diagnosis of borderline personality disorder," *Australian Psychologist*, vol. 51, no. 6, pp. 472–480, 2016.

[64] A. Stapleton and N. Wright, "The experiences of people with borderline personality disorder admitted to acute psychiatric inpatient wards: a meta-synthesis," *Journal of Mental Health*, vol. 28, no. 4, pp. 443–457, 2019.