The Experiences of Fathers of Children with Borderline Personality Disorder

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Abstract

Fathers of children with borderline personality disorder (BPD) represent an underexplored group within the mental health literature. While research has examined the experiences of mothers and families more broadly, little is known about how fathers make sense of their parenting roles and relationships within the complex relational landscape of BPD. This study thus sought to explore the lived experiences of fathers who have a child diagnosed with BPD. To answer the central research question of “what are the experiences of fathers of children with BPD?” I completed several semi-structured, in-depth video interviews with three fathers and then analysed the data using interpretative phenomenological analysis (IPA). The analysis identified four superordinate themes: Powerlessness and the Limits of Fatherhood; Commitment and Connection (or Lack Thereof); Coping with the Ongoing Burden; and Making Sense of BPD and Renarrating Fatherhood. Each superordinate theme had three subordinate themes, each of which pertained to a particular father’s experience in relation to the superordinate theme. Together, these themes illustrated that fatherhood in the context of BPD was marked by enduring love and commitment, yet also profound emotional strain and systemic exclusion for some of the fathers. Effective communication and resisting the urge to try to fix their children’s struggles emerged as processes facilitating relational repair and effective coping for some of the fathers. This research offers an account of fathers of children with BPD as active and reflective, challenging assumptions that position them as peripheral carers. The study underscores the need for family-inclusive mental health services that actively engage fathers, recognise their unique challenges, and support their role in fostering family resilience and recovery.

Chapter 1 Introduction

General Introduction

This research aims to explore the experience of fathers of children with borderline personality disorder (BPD), using interpretative phenomenological analysis (IPA). In this introductory chapter, I will briefly comment on some use of language that will be used throughout this thesis. I will then discuss the background to the study and provide an overview of the relevant literature to this topic. This chapter will then conclude with the study's rationale.

Use of Language

This study is written in the first person to fit with and reflect my epistemological stance. I acknowledge that my own views and experiences have influenced this project and a first person approach to writing allows for my role as an interpreter and co-constructor of meaning to be made explicit throughout the study.

Given the New Zealand (NZ) context of the study, the term 'whānau' is occasionally used, particularly in the discussion. This term is used to reflect the fact that service user support networks often extend beyond biological family, and also reflects the language used by mental health services in NZ (Te Pou, 2022). In this study it is often used interchangeably with 'family' when used in an NZ context (i.e. not when discussing international literature).

The term 'carer' is also occasionally used during the study. This term refers to "a family member, partner, or friend of someone with a mental illness whose life is also affected by that person's illness", who also "provide[s] support and assistance" (NSW Government, 2021).

When discussing previous literature, the term 'child' or 'children' simply refers to parents' offspring of any age. In the context of this study, these terms refer to a father's offspring diagnosed with BPD of any age. All the fathers in this study's children were adults; the ages of these children are provided in the Methods section.

Background to the Study

The last several decades have seen a growing body of research exploring the experiences of parental caregivers of children with mental illness, however very few studies have focused solely on the experiences of fathers, and none have focused on the experiences of fathers of a child with BPD.

Borderline personality disorder is a severe and often chronic mental health condition characterised by pervasive instability in emotions, interpersonal relationships, self-image and behaviour, as well as marked impulsivity which often manifests in self-harming behaviours (American Psychiatric Association [APA], 2013). The disorder typically features a pattern of emotional dysregulation (particularly difficulties managing heightened emotional states such as anger), unstable relationships, identity disturbance, fear of abandonment, feelings of emptiness, stress-related paranoia and recurrent self-harming and/or suicidal behaviours (May et al., 2016).

The prevalence of BPD is estimated to be between 1.6 - 5.9% in the community (APA, 2013), however, rises sharply in clinical settings, reaching 10% amongst psychiatric outpatients and 20% for inpatients (Lieb et al., 2004). Individuals with BPD often face stigmatic attitudes from professionals within the mental health system (MHS) (Bodner et al., 2015; Sansone & Sansone, 2013), sometimes even being outright rejected from receiving treatment (Seigerman et al., 2020). This lack of support from the MHS greatly increases the burden that parents of children with BPD experience (Kay et al., 2018).

The vast majority of the research into the parental experiences of child mental illness has employed either exclusively female participants or a mix of both female and male participants.

Furthermore, in the mixed gender studies, female participants typically greatly outnumber the male participants and results are amalgamated rather than examined with respect to gender (eg. Lindgren et al., 2016; Pejlert, 2001). Over the last several decades, the number of male caregivers has increased (Sharma et al., 2016). Despite this, there is a dearth of research exploring the experiences of fathers of children with mental illness, with no studies focusing on the experiences of fathers of a child with BPD.

Given the absence of literature on the latter, and the paucity of the former, the following literature review will begin with an overview of parents' experiences of caring for a mentally ill child. The review will then build on this by discussing parents' experiences of caring for a child with BPD, highlighting how it is a uniquely challenging diagnosis. The experiences of fathers caring for a child with mental illness will then be discussed, before discussing why the fathers of children with BPD are a compelling and necessary group to explore the experiences of. Prior to examining the aforementioned literature, I will briefly engage in theoretical discussions of family systems theory (Bowen, 1993) and the Double ABC-X Model (McCubbin & Patterson, 1982).

Theoretical Perspectives

Family Systems Theory

Family systems theory (FST) is a useful theoretical lens to make sense of the profound impacts that a child's mental illness has on parents. FST's central premise is that the family is best viewed as an interconnected emotional system, rather than a collection of disparate entities (Bowen, 1993). While individuals in the family unit vary in their level of interdependence, Bowen (1993) argues that interdependence is inherent to some degree; the thoughts, emotions and behaviours of one member of the family always exert some influence on the other members of the family. While this emotional interdependence likely developed evolutionarily to enhance family cohesion and cooperation for survival (Emlen, 1997), when negative emotions - particularly stress (Brown, 1999) - rise in a family system, these same mechanisms can become dysfunctional, leading to reciprocally heightened emotional distress.

Early et al.'s (2002) longitudinal study of 164 families of children with emotional disorders using structural equation modelling found that caregiver well-being and child functioning mutually affect each other over time. It is important for professionals and support service providers to understand the needs and experiences of parents of children with mental illness, as decreased psychological wellbeing in parents has a negative impact on their child also; the relationship is bidirectional.

Double ABC-X Model

Family stress models, such as McCubbin and Patterson's (1982) Double ABC-X model are useful in moving beyond BFST's premise that the family is an emotionally interconnected system into exploring how families respond and adapt to stressors within the family system. The Double ABC-X model expands on the ABC-X model proposed by Hill (1949) to accommodate a focus on long-term family adaptation in response to stressors. The Double ABC-X model incorporates additional variables to capture the dynamic nature of stress over time. These additional variables make the updated model better suited to understand families facing chronic stressors such as mental illness (Boss, 1988).

McCubbin and Patterson's (1982) additions to the model includes the concept of stressor pileup (aA), which accommodates for stressor plurality by acknowledging that families often deal with multiple simultaneous stressors. For parents of children with mental illness, these may include - but are by no means limited to - their child's challenging behavioural symptoms, frustrations navigating the MHS and social stigma.

The model's family resources variable (bB) refers to both pre-existing resources as well as new resources developed in response to ongoing stress (McCubbin & Patterson, 1982). These resources can include relationships; individual development; cognitive, emotional, financial, spiritual and community resources; essentially anything that a family can draw on in response to a stressor (Burr & Klein, 1994).

Hill (1958) argued that a family's perception (C) of the stressor has a significant influence on the crisis outcome; families who negatively define stressors are more likely to experience a crisis than those who assign a positive or neutral meaning to the stressors. Perceptions change over time as families reframe and redefine their experiences (McCubbin & Patterson, 1982). Variable (cC) thus represents the family's evolving perceptions of the stressor, but also their evolving perceptions of their available resources and the crisis (if there is one).

The Double ABC-X model's adaptation variable (xX) captures the long-term outcome of the family's response to stressors. Families with access to adequate resources (bB) and non-problematic perceptions (cC) of the stressor (aA) may not experience a crisis. Conversely, a family lacking in available resources with highly negatively-valenced perceptions of a stressor thus struggles to cope, leading to family dysfunction (Rosino, 2016).

McCubbin and Patterson (1982) describe a range of adaptation outcomes from bonadaptation - whereby the family successful adjusts to the crisis, maintaining functionality, bolstering resilience and restoring equilibrium to the family system - to maladaptation, an unsuccessful adaptation resulting in enduring dysfunction and disequilibrium of the family system.

The Double ABC-X model provides a dynamic framework for understanding the complex and evolving nature of parents' experiences of their child's mental illness. This model will be employed in the following literature review not by serving as an explanatory mechanism, but rather as an organisational tool. The literature currently lacks a structured framework for making sense of parents' experiences. The model will provide conceptual clarity to the literature review and highlight the complex, interconnected and multi-dimensional components of parents' experiences, illuminating the strengths and struggles they face respective to each component of the model.

Chapter 2 Literature Review

Parents’ Experiences of Caring for a Mentally Ill Child

Stressors

The experience of caring for a child with mental illness is highly burdensome. Carers are impacted negatively in a multitude of ways which have been collectively termed ‘caregiver burden’ (Möller-Leimkühler & Wiesheu, 2012). Caregiver burden has been separated conceptually into both objective burden - measurable and concrete challenges - and subjective burden, the negative emotional and psychological stressors experienced due to caregiving responsibilities (Hoenig & Hamilton, 1966). Examples of both forms are evident in the literature.

Parents of mentally ill children can experience a reduced capacity to work; financial loss due to this as well as treatment costs; reduced time for leisure, social connection and hobbies; poorer self-ratings of health; elevated use rates of psychotropic medicines; and increased risk of medical hospitalisation (Möller-Leimkühler & Wiesheu, 2012). Additionally, a meta-analysis of 26 studies by Dey et al. (2019) found that parents of mentally-ill children experience a clinically relevant reduction in their quality of life compared to parents of healthy children.

The psychological impacts on parents of having a child with mental illness are well documented. Parents’ experiences of caregiving are composed of a persistent emotional turmoil. Parents’ caregiving experiences have been described as a “psychological tsunami” (McAuliffe et al., 2014, p. 148), encompassing chronic grief, guilt, and powerlessness as they confront their inability to fix their child’s illness (Greally et al., 2024; Johansson et al., 2012). Many also report isolation due to stigma and a persistent sense of caregiving as an inescapable, lifelong burden (Clarke & Winsor, 2010; Lindgren et al., 2016).

Resources

Formal Supports

Parents of children with mental illness consistently report dissatisfaction with the mental health system (MHS). Their concerns centre on three recurring issues: poor communication, exclusion from care decisions, and professionals' perceived lack of empathy. Parents frequently describe struggling to obtain even basic information about their child's diagnosis, treatment, or management - likened by one participant to "drawing blood from a stone" (Knudson & Coyle, 2002, p. 178). Confidentiality rules are often applied so rigidly that parents feel excluded from treatment planning and discharge processes (Knudson & Coyle, 2002; McCann et al., 2011), leaving them invisible and undervalued within services (Clarke & Winsor, 2010; Pejlert, 2001; Sharma, 2018). As a result, many families are forced into advocacy roles, learning to assert their rights simply to access information or be heard in clinical settings (Sharma, 2018).

Informal Supports

Informal supports - such as family, friends, and peer networks - are often perceived as more helpful than formal mental health services (Ferriter & Huband, 2003). Even the belief that support is available can buffer stress, sometimes more effectively than its actual receipt (Avery et al., 2022; Benson & Karlof, 2009). Spouses commonly serve as the main source of emotional and practical support, though when both partners are struggling, this interdependence can increase distress (Boyd, 2002; Hartley & Schultz, 2015). Broader family and friends can also offer respite, yet many parents hesitate to disclose their child's difficulties due to stigma or fear of misunderstanding (Knudson & Coyle, 2002).

Support groups are frequently identified as one of the most valued forms of informal support, offering empathy, validation, and practical coping strategies unavailable elsewhere

(Lindgren et al., 2016). These groups provide both emotional and informational support and a sense of community with others who understand (Cohen & Wills, 1985). However, for parents new to their role, exposure to others' long-term struggles can sometimes heighten distress (Knudson & Coyle, 2002).

Individual Coping Mechanisms

Given the high burden of caregiving, parents must adopt coping strategies to maintain their wellbeing. Coping refers to the cognitive and behavioural efforts individuals use to manage stress, often grouped into problem-focused and emotion-focused approaches (Lazarus & Folkman, 1984).

Problem-focused coping involves attempting to change the source of stress through information seeking, practical action, or support mobilisation. Many parents report an initial surge of activity following diagnosis, seeking information and strategies to better manage their child's condition (Huang et al., 2008). Support-seeking can alleviate burden, though stigma, isolation, and cultural barriers sometimes limit its use (Huang et al., 2008; Knudson & Coyle, 2002).

Emotion-focused coping is used when stressors feel uncontrollable and focuses on regulating emotional responses. Parents describe maintaining work, hobbies, or other activities to sustain normality (Clarke & Winsor, 2010; Lindgren et al., 2016). Over time, many shift from active problem-solving to acceptance - an important transition that alleviates distress once efforts to fix the situation prove ineffective (Knudson & Coyle, 2002). Strategies such as reframing, downward comparison, and faith can also promote resilience (Bellingham, 2012; Kartalova-O'Doherty & Doherty, 2008). Emotion-focused strategies that emphasise acceptance and meaning making appear more adaptive than avoidance or denial, which are associated with poorer psychological outcomes (Carver et al., 1989; Kartalova-O'Doherty & Doherty, 2008).

Parents tend to engage in both problem and emotion-focused coping strategies, however there is typically a temporal pattern to when each is adopted. After initially receiving a diagnosis, parents tend to engage in problem-solving coping to try and improve their child's condition. If over time these strategies prove ineffective, parents tend to transition into adopting emotion-focused coping strategies as a means to cope with the immutability of their situation.

Perceptions

Parents' perceptions of stressors and resources shape their capacity to adapt (McCubbin & Patterson, 1982). Many view their child's illness as an immense and enduring challenge, accompanied by grief and hopelessness when repeated efforts to help fail (Greally et al., 2024; Svensson et al., 2013). Feelings of self-blame are common, as parents internalise stigma and attribute their child's illness to personal shortcomings (Harden, 2005). Despite their challenges, parents routinely describe a resolute commitment to caring for their child (Greally et al., 2024).

Parents rarely perceive the MHS as a genuine resource. While some acknowledge positive encounters with empathetic professionals, most describe formal services as inadequate or dismissive, often intensifying their sense of powerlessness (Greally et al., 2024); McCormack & McCann, 2015). Perceptions of informal support vary: parents who experience understanding from friends or peers describe relief and validation, whereas others withdraw through fear of judgment or misunderstanding (Knudson & Coyle, 2002; Lindgren et al., 2016).

Adaptation

Adaptation to a child's mental illness is often marked by chronic anxiety, relational strain, and gradual acceptance. Parents describe living in a persistent state of anxiety, worrying not only about relapse or self-harm, but also about their child's long-term future and their own capacity to continue caring (Bellingham, 2012; Greally et al., 2024). Many report ongoing uncertainty and helplessness, fearing what will happen when they are no longer able to provide support (Kalayci et al., 2023; Piuva & Brodin, 2020).

A child's illness can also disrupt family relationships. Conflict commonly arises over caregiving strategies or perceived imbalances in effort, often reducing time and emotional availability within the family (McAuliffe et al., 2014; McCormack & McCann, 2015). Over time, however, some families describe a rebalancing process in which communication and mutual understanding improve (McCormack & McCann, 2015; Piuva & Brodin, 2020), consistent with research showing that many families eventually achieve functional adjustment (Schön et al., 2009).

Many parents describe a gradual and precarious process of finding acceptance, typically not because they wanted to, but because they had to in order to endure their experience (McAuliffe et al., 2014). Greally et al.'s (2024) model of parental adjustment captures this shift from stress and uncertainty to acceptance and renewed purpose, though the process may be protracted and fragile.

Parents of Children with BPD's Experiences

The amount of subjective burden experienced by parents of children with BPD has been found in a Dutch sample to be similar to parents of children with schizophrenia, with both groups experiencing significantly more burden than parents of depressed or anxious children (Van den Boogaard et al., 2004, as cited in Scheirs & Bok, 2007). The high burden resulting from caring for a child with BPD has been attributed to its unique nature, particularly the relational volatility and unpredictable behaviours inherent to the condition, coupled with cyclical crises and the typical chronicity of BPD (Tariq & Mishra, 2025). Parents struggle to find their emotional footing as they regularly grapple with sudden and severe mood fluctuations from their child (Skodol et al., 2002).

Stressors

Parents of children with BPD experience numerous stressors, initially resulting from the symptoms of the condition, with pile-up stressors building over time. The child's behavioural and emotional dysregulation creates an environment of instability within the family and results in chronic hypervigilance in their parents (Kay et al., 2018); they feel as though they must constantly monitor their interactions with their child in order to avoid triggering distress (Bailey & Grenyer, 2013; Ekdahl et al., 2011; Seigerman et al., 2020).

This hypervigilance serves not only to protect parents from experiencing negative interpersonal dynamics, but also serves to protect their children from self-harming or suicide attempts, which are extremely common (Black et al., 2004; Lawn & McMahon, 2015; Lieb et al., 2004). Parents describe a pervasive sense of dread regarding impending self-harm or suicide events (Ekdahl et al., 2011). This experience of cyclical crises amplifies parents' emotional exhaustion and leads to increased negative psychological symptoms, such as anxiety, depression and helplessness (Bailey & Grenyer, 2014; Tariq & Mishra, 2025).

Parents also experience considerable financial strain as a result of caring for their child, primarily attributable to expenses for therapy, hospitalisations and crisis interventions (Buteau et al., 2008; Goodman et al., 2011). Impulsive spending is a common behaviour for individuals with BPD (Maraz et al., 2016), often leading to spiralling debt which falls upon the parents (Buteau et al., 2008; Dunne & Rogers, 2013).

Resources

Formal Supports

Despite BPD's severe impact, parents overwhelmingly report dissatisfaction with formal mental health services. Parents often struggle for adequate information and inclusion in decision making; in an Australian sample, 62.4% of participants reported that BPD was not explained to them by the professional that made the diagnosis (Lawn & McMahon, 2015). Additionally, 48.6% of participants reported never having involvement in decision making about their child's treatment and care, either being omitted or outright rejected. Parents frequently describe being excluded from care decisions, sometimes under the pretext of confidentiality, which leaves them uninformed yet responsible for managing crises once their child returns home (Ekdahl et al., 2011; Giffin, 2008).

While parents of children with BPD share many similar struggles with parents of mentally ill children regarding the MHS, they also have uniquely difficult experiences, primarily attributed to the highly stigmatised nature of BPD. Clinicians have historically viewed individuals with BPD as overly difficult, attention-seekers, or beyond help (Hoffman et al., 2005; Lawn & McMahon, 2015; Rogers & Acton, 2012; Stroud & Parsons, 2013) - attitudes that parents perceive as extending toward them also. Some report being implicitly blamed for their child's condition, with staff questioning their early attachment or parenting (Buteau et al., 2008). Hoffman et al. (2005) describe this as surplus stigma, exceeding that encountered by carers of individuals with other diagnoses.

Despite parents' overwhelming dissatisfaction with formal supports in the MHS, parents have positive evaluations of psychoeducational courses such as Family Connections, a 12-week Dialectical Behaviour Therapy (DBT)-informed intervention for family members. Family

Connections has consistently been shown to reduce burden and grief while increasing mastery (Hoffman et al., 2005; Joyce et al., 2024; Krawitz et al., 2016).

Informal Supports

Informal supports are theoretically a great resource for parents to draw on, however, they often end up contributing further stress to parents. While some parents report shrinking social circles due to the exhaustion and reduced free time associated with caring (Meshkinyazd et al., 2020), parents' diminishing sense of social support and connectedness is often due to experiences of stigma (Meshkinyazd et al., 2020).

Parents in several other studies report negative interactions with their social networks. Parents experience friends and family saying that they are frustrated with hearing about their problems so frequently (Buteau et al., 2008). They also report facing criticism that they are mishandling the difficulties arising from their child's BPD symptoms or that they are being overly supportive and need to back away (Buteau et al., 2008; Giffin, 2008). These cumulative factors result in parents experiencing significant social isolation which compounds the burdens they experience in the roles as carers.

Individual Coping Mechanisms

The literature unfortunately reveals little discussion of parents' coping strategies. The fact that parents are coping poorly is briefly discussed in three studies (Buteau et al., 2008; Kay et al., 2018; Seigerman et al., 2020), however the means by which these parents attempt to cope is not explored qualitatively. Outside of these brief discussions and findings, to my knowledge, there is no available information on the coping strategies of parents of children with BPD.

Perceptions

Unfortunately, parents largely feel invisible, judged, excluded, stigmatised, and thus essentially don't perceive formal or social supports as actually being resources which they can draw on to cope with their situation. Parents describe feeling alone and isolated in their struggles. These experiences with resources that are purportedly there to support parents contribute immensely to parents' perceptions of their situation as hopeless (Scheirs & Bok, 2007).

The concept of hopelessness has been discussed extensively in the literature on parents' experiences of caring for a child with BPD and recurrently emerges as a major theme. The caring experience for these parents is emotionally exhausting due to the constant crisis management inherent to the BPD-carer relationship (Steele et al., 2019). Parents in Buteau et al.'s (2008) study near-universally reported profound hopelessness as a central feature of their life as a carer. This hopelessness was attributed to recurrent failures with treatment and the MHS, inadequate support from others, financial troubles and emotional burnout; these parents believed that neither their life nor their child's life were ever going to improve. Some parents described their experience as a "death sentence" while others said that they "didn't want to cope anymore" (Buteau et al., 2008, p.10)

Tariq and Mishra (2025) compared this to Seligman's (1975) concept of learned helplessness, whereby after successive crises, parents begin to feel that their efforts are futile and abandon all optimism for the future. This is consistent with Krawtiz's (2004) finding that hopelessness is especially prevalent in family carers who have made extensive efforts to engage their relatives in treatment strategies, yet feel that no progress is being made.

Adaptation

The literature appears to almost exclusively reveal maladaptation in parents due to the typical chronicity of BPD. The intense burden and stressors that parents experience, compounded with the lack of support from resources contributes to poor coping and a pervasive sense of hopelessness. The only currently empirically supported treatments for BPD are DBT and mentalisation-based therapy (May et al., 2016; Vogt & Norman, 2019). Despite these two modalities - particularly DBT - showing efficacy in the treatment of BPD, they can be difficult to access for families due to availability, financial barriers and requiring the long-term commitment of the child.

The only positive adaptation revealed in the literature is found in quantitative studies which identify a decrease in several burden measures after parents attend courses such as Family Connections (Hoffman et al., 2005; Joyce et al., 2024). This is likely attributed to these programs' focus on providing parents with psychoeducation as well as BPD-specific communication skills.

It is possible that sampling bias contributes to this rather bleak outlook for parents; potentially parents that have adapted well to their situation have not participated in research yet.

The Experiences of Fathers of Children with Mental Illness

Given that there has been no literature published on the experiences of fathers of children with BPD, the literature exploring the experiences of fathers of children with mental illness will be discussed to provide insight into fathers' experiences as carers when any form of mental illness is present in their child. While there appear to be experiences of caregiving which are untethered to gender, the limited research into the experiences of fathers of children with mental illness highlights that there is a uniquely male experience of caregiving which presently remains insufficiently explored.

A handful of studies have examined the experiences of fathers of children with schizophrenia specifically (eg. Howard, 1998; Nyström & Svensson, 2004; Pfeiffer, 2001; Sharma, 2018; Wiens & Daniluk, 2009; Wintersteen & Rasmussen, 1997). To my knowledge, only one study has examined the experiences of fathers of children with any form of mental illness (Johansson et al., 2012), however another study examined the experiences of men caring for family members with any form of mental illness, of which half were caring for their child and half for their wives (Fraser & Warr, 2009).

Stressors

After receiving confirmation of their child's diagnosis, fathers have reported responding with shock, denial and guilt due to not noticing the signs earlier (Wiens & Daniluk, 2009; Wintersteen & Rasmussen, 1997). The early stages of their journey are marked by stress and chaos as these fathers enter new territory where previous experience and skills cannot suffice to achieve control over the situation (Nyström & Svensson, 2004). This lack of control is cited in several studies as being particularly stressful and difficult for these fathers to deal with (Nyström & Svensson, 2004; Wiens & Daniluk, 2009).

Crisis situations are cited as particularly emotionally difficult, such as the guilt and distress experienced after calling the authorities to get their child compulsory treatment (Johansson et al., 2012; Pfeiffer, 2001), the persistent fear of suicide attempts (Johansson et al., 2012) and the emotional toll of crisis situations - particularly those where a child becomes violent towards the father, often resulting in the father being forced to live separately from their child to ensure their safety (Johansson et al. 2012, Sharma, 2018).

Fathers often report feeling helpless and powerless in the face of the illness; they are unable to protect their child from the illness and thus report struggling with feelings of failure and inadequacy as a father (Johansson et al., 2012; Sharma, 2018). As their child grows into adulthood, some fathers report an internal conflict between wanting to support their child's independence while simultaneously recognising that they are unable to complete many basic tasks on their own (Sharma, 2018). With the understanding of the disabling nature of their child's illness follows a sense of mourning and grief of both their child's life and their own.

Through interviews with six fathers of children with schizophrenia, Wiens and Daniluk (2009) highlight five specific losses that these fathers experienced: loss of who their child once was, loss of their child's potential to be a productive contributor to society, loss of their dreams for their child's future, loss in their own lives and families, as well as loss of their hopes and dreams for their own future. Many fathers report feeling chronically worried about the child's future, particularly when they themselves pass away and are not able to continue providing support for their child (Howard, 1998; Wiens & Daniluk, 2009).

Additionally, these fathers experience objective burden. Some of the fathers in Howard's (1998) study on the experiences of fathers of adult children with schizophrenia reported themselves and their wives working overtime after delaying retirement or selling their house to afford their child's hospital bills. Many fathers found themselves pulled out of work due to having to respond to crisis calls while simultaneously needing to work more than ever due to the financial strain of schizophrenia (Pfeiffer, 2001). Fathers thus experience stress over maintaining employment while managing their child's needs (Johansson et al., 2012).

Many of these stressors are chronic and compounding and under the Double ABC-X Model, require access to sufficient resources to mitigate their impact.

Resources

Formal Supports

While the majority of fathers report very negative experiences with the MHS, some fathers report positive experiences. Fathers' evaluation of the MHS appeared contingent on the degree to which they felt valued and involved in communications with staff. When intervention was early, communication with the family was consistent, parents felt included in care and discharge planning, and staff were perceived as empathetic, fathers were complimentary of mental health services (Sharma, 2018; Wiens & Daniluk, 2009).

Unfortunately, positive experiences were only reported in two studies, and even then only were briefly mentioned. Overwhelmingly, fathers' experiences were negative due to the absence of the aforementioned criteria. Fathers frequently reported feeling stigmatised, unvalued and even threatened by staff, shut out from communication and thus uninvolved in care and discharge planning (Johansson et al., 2012; Nyström & Svensson, 2004; Sharma, 2018; Wiens & Daniluk, 2009). When fathers were given space to be actively involved in a collaborative relationship with staff, they reported obtaining value from this 'quasi-professional' role (Fraser & Warr, 2009).

However, fathers predominantly end up adopting this role due to feeling forced to advocate for their child. Fathers in Sharma (2018) reported only being able to have their child's needs met after threatening to or actually making complaints to senior staff, while in Fraser and Warr's (2009) study, fathers reported keeping their own notes of their child's medical history due to staff making mistakes and keeping inaccurate records. This need to advocate in order to obtain quality service is rife throughout the literature, and has resulted in many fathers losing faith altogether in the MHS (Johansson et al., 2012)

Informal Supports

Fathers of children with mental illness commonly report having a very small circle of confidants which are privy to their situation and for whom they rely on for support. Most of the fathers in both Pfeiffer (2001) and Wintersteen and Rasmussen's (1997) studies cited only one to two people other than their wife that they relied on for support. This was typically their siblings, sometimes their parents and friends, and occasionally co-workers or neighbours. The latter two typically ended up in a support role due to involuntary exposure, with the fathers being unable to prevent them from witnessing the effects of their child's illness, such as ambulances arriving or having to suddenly leave work.

Many fathers report either an intentional withdrawal from social connections, or their social connections withdrawing from them. When the fathers chose to withdraw from their social connections, this came from a belief that no one wanted to hear about their situations or emotional burdens (Pfeiffer, 2001), or that their social connections simply would not understand (Sharma, 2018). More often though, isolation was the result of social connections drifting away from the fathers. This is consistent with the broader psychosis carer literature which finds that carers of people with psychosis are roughly 10 times more isolated than noncarers, and significantly more isolated compared to carers of people with health difficulties (Hayes et al., 2015; Magliano et al., 2005; Perlick et al., 2005; Sharma, 2018). Carers of people with mental illness experience a unique and profound form of stigma and shame which drastically impacts their perceived or real access to social support (Magliano et al., 2005; Gutierrez-Maldonado et al., 2005).

Support groups are inconsistently used by fathers, which reflects the trend for help-seeking rates to be very low among males for psychological difficulties (Yousaf et al., 2015). Fathers often found themselves being the only male present at support groups (Fraser & Warr, 2009; Sharma, 2018). Typically, fathers that did attend these groups reported the groups being a positive experience, enabling them to cope more effectively with their caregiver role and connecting them to other parents who could genuinely understand their experiences (Fraser & Warr, 2009; Nyström & Svensson, 2004; Pfeiffer, 2001; Sharma, 2018).

Individual Coping Mechanisms

A clear and recurring theme in the literature is that fathers tend to adopt problem-focused coping mechanisms, which are characterised by their practical and solutions-focused nature. Fathers engage in extensive information seeking in the early stages of their journey as a means of coping with the burden of their child's condition. Fathers commonly report researching their child's condition and engaging in detailed record-keeping to regain a sense of coherence and control as well as enable them to act as an advocate for their child within the often chaotic and nebulous MHS (Fraser & Warr, 2009; Howard, 1998; Wiens & Daniluk, 2009).

Additionally, this gave the fathers the information required to create management plans and strategies for dealing with their child's condition and challenging behaviours (Fraser & Warr, 2009). With knowledge of their child's condition, fathers were able to channel their tendency for hypervigilance and a desire to take practical action into symptom monitoring of their child, thus providing them with the tools to respond to particular symptoms and knowledge of the warning signs of deterioration indicating a need for rehospitalisation (Johansson et al., 2012).

Fathers often adopted the role of the provider of practical support by taking care of their child's living arrangements and financial affairs, managing appointments with formal support services and providing transport to appointments (Nyström & Svensson, 2004). Unfortunately, the protracted and sometimes chronic nature of mental illness means that despite fathers' best efforts to find solutions to their child’s problems, their efforts are not enough to solve their child’s mental illness. Fathers then must turn to emotion-focused coping mechanisms to cope with the ongoing burden of care.

While mothers have also been reported to engage in information seeking and problem-focused coping mechanisms early in the post-diagnosis journey, they also readily engage in emotion-focused coping mechanisms such as reaching out to informal supports like friends, family and support groups. Conversely, fathers, if they engage at all with informal supports, tend to take a much longer time to do so, preferring to withdraw and turn inwards. This is one of the key differences between maternal and paternal patterns of coping.

For example, in Wintersteen and Rasmussen’s (1997) study, for families who turned to religion for support, the mothers found support in church women’s groups or social contacts, while the fathers found support in private prayer and clergy sessions. The fathers also tended to turn to work and activities to distract themselves from their emotional pain and allow themselves private spaces to process their grief, while the mothers readily reached out to more public forms of support. The fathers in Howard (1998) and Nyström and Svensson’s (2004) studies reported similar patterns of private, vocation-based coping.

Wintersteen and Rasmussen (1997) argue that fathers tend to retreat inwardly for reflection and comprehension before feeling comfortable to seek support beyond themselves. This is congruent with the findings of systematic reviews of the coping mechanisms of male caregivers (Spendelow et al., 2017) and fathers of chronically ill children (Haraguchi, 2023), whereby male carers tend to retreat inwards and gather information as a means of regaining control and a better outward perception of competency prior to making themselves vulnerable by reaching outwards.

Despite appearing to experience less grief and emotional burden than their maternal counterparts due to this tendency, Cook (1988) argues that this grief simply manifests differently to women’s grief, largely due to men’s considerable effort at managing or controlling their feelings, and is thus difficult to capture when assessed through the typical physical and psychometric inventories. Cook (1988) believes what is thus needed in research into fathers’ experiences is a focus “on emotions as men experience them and [an attempt] to uncover nonsocial forms of emotional experience" (p. 306). Masculinity is integral to understanding male coping and will be explored in a later section.

Perceptions

Under the Double ABC-X model, fathers’ perceptions of their stressors and their resources influence their adaptability and resilience. Related to this is fathers’ perceptions of what it means to be a father to someone with mental illness, as this influences how they respond to stressors and their engagement with resources. Fathers’ perceptions of resources were discussed in the Experiences of Fathers of Children with Mental Illness: Resources section and thus will not be covered comprehensively here. In short, fathers largely perceived the MHS and their social networks as being ineffective resources, often feeling excluded from both.

Fathers’ perceptions of their child’s mental illness are scarcely mentioned in the literature, with only passing mentions in two papers. In Johansson et al.’s (2012) study, some of the fathers maintained that mental illness was not something that should be hidden, as they had negative experiences with mental illness in their family being hidden during childhood. In Sharma’s (2018) study, the fathers had a rather dejected and hopeless perception of their child’s mental illness. They were plagued by a pervasive lack of meaning making with regard to the illness. They could not understand why their child had become ill and struggled to understand their own experience of supporting their child, despite significant efforts. Many fathers perceived their child's illness as completely immutable, reporting that without a miracle they could not imagine their child's situation improving.

For many fathers, caring for their child with mental illness simply extended the typical obligations and responsibilities inherent to their role as a father. These fathers felt that despite the circumstances being greatly more difficult than they had imagined, they were just fulfilling their role as a father - taking responsibility for the ongoing care of their child was never questioned (Fraser & Warr, 2009; Sharma, 2018). However, the dual roles of father and carer could create conflict, particularly when difficult decisions had to be made such as requesting an involuntary hospitalisation take place, as the fathers knew it was necessary for their child's wellbeing but struggled with feeling they had damaged their relationship with their child (Johansson et al., 2012; Sharma, 2018). Fathers in Sharma's (2018) study also expressed disappointment due to their expectations of what a father/child relationship should look like failing to align with reality. Additionally, some of the fathers in Nyström and Svensson's (2004) study reported feeling like failures as fathers due to not being able to protect their child from the condition.

Adaptation

Relationships (Wife)

The impact that caring for their ill child had on fathers' relationships with their wives has only been examined in a small number of studies, and even so was often only briefly discussed by their author(s). Of these limited studies, fathers' reports of their marital adaptation to their child's illness vary considerably both within and across these studies. Some studies reported negligible negative effects on the marriage as a direct result of their child's illness (Pfieffer, 2001), while in others, every participant reported that their relationship with their wife deteriorated (Nyström & Svensson, 2004). Others reported a largely even ratio of fathers' marriages being negatively affected, unaffected, or positively affected by their child's illness (Wintersteen & Rasmussen, 1997).

While these studies' small sample sizes are likely partially responsible for this considerable variation, the perceived degree of paternal involvement in caregiving has been identified as predicting marital satisfaction amongst parents of mentally ill children. West and Honey's (2016) analysis of interviews with families affected by child mental illness identified four models of paternal involvement ranging from collaborative to disengaged. These models were distinguished by the father's level of direct engagement, support for the mother, and shared responsibility in caregiving.

At the most collaborative end, the co-pilot model described parents who jointly supported their child and each other, reporting the highest satisfaction and marital cohesion - findings consistent with Pfieffer's (2001) observation that shared caregiving can strengthen couple relationships. The captain/first-mate and gondolier models reflected decreasing paternal engagement, with mothers assuming most responsibility and greater risk of stress and conflict. At the least collaborative extreme, the separate driver model depicted parents working independently, often with misaligned strategies and mutual blame. Similar patterns were noted in Pfieffer's (2001) study, wherein these couples reported heightened marital tension and dissatisfaction.

Relationships (Child)

Of the studies that examine the outcomes of their child's mental illness on the fathers' relationships with their child, most highlight a process of a rather profound and painful transformation. This transformation is characterised by disrupted relational dynamics, grief over lost expectations and adaptive renegotiation of father-child bond.

The fathers in Sharma's (2018) study describe a process of previously close relationships becoming either distant or unstable, with fluctuations between emotional closeness and detachment occurring depending on the child's mental state, whether they were in hospital or taking drugs. Additionally, previously shared activities that once strengthened their bond, such as attending sports events or concerts, were no longer viable, leading to a sense of lost companionship. These fathers also reported struggling with shifting roles that conflicted with traditional father-child scripts, such as treating their offspring like a perpetual child, constantly having to monitor their basic daily tasks rather than spending quality time together or engaging in peer-like conversations. Similarly, many fathers mourned the loss of the relationship they envisioned having with their child. One father in Sharma's (2018) study described sadness that their relationship with their child was "not as good as it was or even as good as it should be" (p. 72).

Thus, these fathers needed to find ways to rebuild a meaningful connection with their child. Wiens and Daniluk (2009) highlight instances of fathers developing admiration for their child's resilience, expressing pride in their efforts to manage the illness. Others described consciously aiming to focus on small victories rooted in tempered expectations rather than comparing their child's state and progress to the imagined future they had for their child. The degree to which fathers could achieve acceptance of the redefined relationship appeared to influence their level of ongoing emotional burden regarding their relationship with their child.

Individual Adaptation

For fathers' own long-term outcomes and adaptation, they describe a complex emotional landscape containing both enduring challenges and opportunities for growth. Wintersteen and Rasmussen (1997) found that the fathers who had appeared to find relief from the burdens of their situation were those who had taken efforts to access resources and support and were willing to open up to others about their experience. Conversely, the fathers that did not engage in these behaviours took far longer than their wives to find acceptance - if they ever did - and were struggling to cope. These fathers reported persistent difficulties with sleep, mood or appetite, plus sustained withdrawal and emotional suppression. These findings are consistent with the Double ABC-X model in that the degree to which resources are accessed influences the outcomes and adaptation of fathers undergoing chronic stressors (McCubbin & Patterson, 1982).

Other studies highlighted that the fathers' wellbeing was contingent on the wellbeing and age of their child. Aside from one father in Sharma's (2018) study, all fathers had been caring for their child for over a decade. Despite this, many fathers still struggled to make sense of their child's illness. They reported trying to reconcile some form of hope for the future with the enduring sense of helplessness they felt due to their child not yet becoming well, despite considerable effort. This is consistent with Addington et al.'s (2003) finding that caregivers' emotional well-being was associated with their understanding and evaluation of their care recipients' illness.

The hope that Sharma's (2018) more experienced fathers continued to hold was stronger in fathers in Fraser and Warr's (2009) study who had a younger child and were early in their caregiving journey. These fathers expressed hope that with resources and support, their child would be able to recover. This hope appeared to be dashed in the fathers of older children after their children reached adulthood but struggled to achieve independence. The authors highlighted a considerable increase in chronic tensions and strains experienced by these fathers due to this.

Despite the significant chronic burden that many fathers of mentally ill children feel, fathers also report positive outcomes of their experiences, typically regarding personal growth and becoming a better father. When reflecting on their initial parenting, some fathers expressed remorse which motivated them to deliberately parent differently after their child's illness emerged (Wiens & Daniluk, 2009). Personal growth and evolution as a father then became an important part of their journey. These fathers described gaining a greater understanding of themselves as fathers throughout the course of their child’s illness. This helped them to make meaning of their experiences and inspire change in the way they lived their lives.

Similarly, fathers in Nyström and Svensson’s (2004) study discussed how they felt their personality had positively shifted due to feeling more empathetic, resilient and certain of what really matters in life. This often manifested in these fathers getting more involved in family affairs, becoming more committed in their marriages and their relationships with their children, perceiving themselves as advocates for their families, and being more sensitive to the struggles of others in the world (Fraser & Warr, 2009; Howard, 1998; Nyström & Svensson, 2004; Wiens & Daniluk, 2009; Wintersteen & Rasmussen, 1997).

These findings are consistent with Tedeschi and Calhoun’s (2004) concept of post-traumatic growth (PTG), defined as “positive psychological change experienced as a result of the struggle with highly challenging life circumstances” (p. 1). According to the authors, PTG manifests in five different ways: a greater general appreciation for life, more meaningful relationships, increased perceived personal strength, shifts in priorities and re-evaluating one’s way of living, and a more existential, spiritually-rich existence. PTG is viewed as both a process and an outcome; PTG represents a positive outcome in its own right, given its association with increased life satisfaction in the long run, yet PTG also describes the gradual journey of processing trauma and recognising beneficial changes over time. The outcome of PTG thus emerges rather late into the adaptation process.

We see evidence of PTG in the previous adaptation section, particularly with regards to the fathers which expressed personal growth as a result of their experience. Through their many years of painful experiences and reflection, these fathers felt more certain of what truly matters to them in life, adopted a more empathetic worldview, became more invested in their relationships, adopted new roles and developed more coherent narratives of what it meant to be a father (Fraser & Warr, 2009; Howard, 1998; Nyström & Svensson, 2004; Wiens & Daniluk, 2009; Wintersteen & Rasmussen, 1997).

Masculinity

The experiences of fathers of children with mental illness are deeply intertwined with their embodiment of societal expectations of masculinity - specifically, hegemonic masculinity.

Hegemonic Masculinity

Hegemonic masculinity refers to the culturally dominant and most valorised form of masculinity within a society which occupies a superior position, relative to other gender identities, due to the status it typically brings those who embody it (Connell, 1987; 1995; Connell & Messerschmidt, 2005). In Western cultures, hegemonic masculinity tends to refer to traits such as assertiveness, physical and emotional toughness, courageousness, and unwavering stoicism in challenging circumstances (Connell, 1987). The hegemonic ideal promotes demonstrations of strength and resilience while stigmatising vulnerability, emotional expression, or dependence on others. Connell (1987) emphasises the socialisation of hegemonic masculinity, in that it represents a prescribed and socially constructed ideal which must be learned and performed, rather than an innate quality of men generally. Additionally, it is not described as a desirable reality for men, but rather a normative standard which men feel obligated to perpetuate, typically with detrimental implications (McVittie et al., 2017).

Hegemonic Masculinity Scripts

Mahalik et al. (2003a) describe seven hegemonic masculinity ‘scripts’ which contribute to men’s presenting concerns in psychotherapy and simultaneously act as barriers to help-seeking. Of these, four are relevant to the current study. The ‘strong and silent’ and ‘tough guy’ scripts both refer to the socialised repression of emotion evident in men that embody hegemonic masculinity. Men that enact these scripts live up to masculine role expectations through exhibiting stoicism and control over one’s feelings by suppressing emotions that could be associated with vulnerability. Male emotional suppression has been associated with numerous adverse outcomes such as fear of intimacy (Cournoyer & Mahalik, 1995; Fischer & Good, 1997; Good et al., 1995), higher levels of depression (Cournoyer & Mahalik, 1995; Good & Mintz, 1990; Good et al., 1996), anxiety and anger (Blazina & Watkins, 1996), and higher levels of alexithymia - difficulty in identifying, understanding and expressing emotion (Fischer & Good, 1997).

There is evidence of this script emerging in some of the fathers literature, such as one father in Pfieffer’s (2001) study who continually minimised his own struggles by saying that he was not the one suffering - his child was. Fathers in Johansson et al.’s (2012) study reported difficulties expressing their emotions, opting instead to convey a strong facade, which they believed was crucial to be able to manage the difficult circumstances. Additionally, several wives in Wintersteen and Rasmussen's (1997) study reported never having seen their husbands grieve or show visible signs of emotion.

Another pertinent script for the current study is the 'independent' script. Men who follow this script place great importance on self-sufficiency and being strong in one's ability to get through adversity independently. These men are typically uncomfortable with exhibiting attachment to others, and feel uncomfortable with asking for assistance from others. Mahalik et al. (2003b) found that men's adherence to this script was associated with increased psychological distress and decreased willingness to seek psychological help. More generally, help-seeking rates have been found to be consistently low among men for medical and psychological problems (Yousaf et al., 2015).

Embodiment of this script is evident in several of the previously discussed studies in the fathers' literature. For example, the fathers in Wintersteen and Rasmussen's (1997) study who turned to religion as a coping mechanism did so through private, self-contained acts of prayer, whereas their wives primarily found support in the church community. Following their child's diagnosis, the majority of these fathers coped by busying themselves with work and activities, and did not engage with social or professional supports for many years, if they did at all. The independent script is also evident in Cluley's (2015) research on the experiences of fathers of children with cancer; several of the fathers in her study described taking a 'lone wolf' approach to their caregiving journey, wherein they relied on their inner strength and resources and self-sufficiency to get through difficult times.

The final script which is of relevance to the current study is that of the 'winner'. This script reflects the components of hegemonic masculinity which place high value on success and a competitive nature. Accordingly, men who adhere to this script place great emphasis on their career and achievements, and whether explicitly or implicitly, evaluate their masculinity and thus themselves based on these attributes. A common theme in the fathers' literature is the struggle to find a balance between caregiving responsibilities and being a 'breadwinner', which remains a significant foundation for men's identities (Brandth & Kvande, 1998; Fraser & Warr, 2009).

The norms underpinning these scripts create significant barriers to help-seeking. Many men view admitting distress or seeking help as a threat to their masculinity, fearing it signals weakness or failure (Addis & Mahalik, 2003). As a result, fathers may delay or forgo assistance, exacerbating their stress and isolation (Fraser & Warr, 2009).

It is important to note that fathers' embodiment of hegemonic masculinity can be adaptive with regards to caregiving. While some fathers who adopt a more traditional masculinity may struggle with emotional support, they tend to be readily willing to engage in practical support (Spendelow et al., 2017). Fathers' rapid, practical responses to their child's illness are valuable, as information seeking gives these fathers a greater understanding of their child's illness and potential treatments, thereby assisting in care management and strategy building, and facilitates greater empathy with regards to some of their child's difficult behaviours (Fraser & Warr, 2009). Additionally, as hegemonic masculinity values assertiveness and fathers' roles as protectors (Wojnicka, 2021), fathers in several studies reported needing to act as advocates for their child and to be assertive with services in order to get their child's needs met (McCann et al., 2011; Sharma, 2018).

The crucial point is that these adaptive outcomes of subscription to hegemonic masculinity are only adaptive for the child; for fathers' own wellbeing outcomes, subscription to hegemonic masculinity is largely maladaptive. O'Neil's (1981) concept of gender role conflict describes the psychological tension and behavioral restrictions men experience when societal expectations of masculinity conflict with their personal needs, values, or circumstances. It arises from rigid adherence to traditional masculine norms (e.g., emotional restraint, dominance, self-reliance), leading to negative consequences in mental health, relationships, and help-seeking behaviors (O'Neil, 2008).

Non-Hegemonic Masculinities

Other forms of masculinity are possible, however. Hegemonic masculinity is simply the most valorised and culturally dominant form of masculinity; it does not describe the inherent qualities of being a man, but rather a form of masculinity which is socially conditioned and reinforced. Men are a vastly heterogeneous population and differ in their personal subscription to and embodiment of these norms. Connell's (1995) work describes alternative non-hegemonic masculinities including those which are complicit (not fully embodying hegemonic masculinity but deriving benefit from it), subordinate (actively opposed to hegemonic masculinity) or marginalised (excluded or silenced within a society which prioritises hegemonic masculinity).

Kaplan et al. (2017) introduced the concept of a 'new masculinity' that prioritises authenticity, personal growth, and emotional openness in close relationships. This progressive model emphasises self-awareness, holistic well-being and nurturing connections with others, consciously rejecting the restrictive norms of hegemonic masculinity. Rather than conforming to conventional gender expectations, this evolved masculine ideal values genuine self-expression and interpersonal vulnerability as strengths rather than weaknesses. This concept is largely synonymous with Elliott's (2016) concept of 'caring masculinities'.

Due to the paucity of literature on fathers' of mentally ill children, there is little discussion of these forms of non-hegemonic masculinities emerging in fathers' approach to caregiving. Perhaps the only direct mention of this is Johansson et al.'s (2012) brief mention of some fathers' 'hybrid' approaches to paternal caregiving, whereby fathers combined elements of traditional masculinity with a deeply involved approach to caring. Russell (2001) also saw this approach in men who were primary caregivers for spouses with dementia.

Summary of Literature Review and Research Question

In recent years, a significant amount of research has been conducted into the experiences of parents of children with mental illness. These studies have primarily had mothers as their participants, and research specifically examining fathers' experiences is sparse. This research has highlighted that while many of the aspects of the parental care experience are shared between mother and father, namely the intense subjective and objective burden, men appear to cope differently. This coping is typically problem-focused, whereby fathers are focused on trying to fix a situation or improve their child's condition. If a situation is unable to be changed, fathers appear hesitant to engage in support seeking, and can become withdrawn to the detriment of their own wellbeing and their relationships with others.

The limited research on the experiences of parents of children with BPD highlight that it is an incredibly difficult condition to have in a child, characterised by cycles of crisis and interpersonal challenges. Without commitment to a long and intensive DBT program, it can be extremely difficult to treat BPD. This means that problem-focused coping mechanisms only go so far in helping parents get by. Additionally, individuals with BPD often struggle with abandonment anxiety, meaning that withdrawal from fathers is likely to further exacerbate difficulties in their relationship with their child. Given that men appear more reliant on problem-focused coping mechanisms and are less willing to seek support or help, I am interested in how the fathers of children with BPD manage to cope with their experiences and make sense of them. There is currently no research exploring this. Thus, this study endeavours to be the first to do so, and asks the question: “what are the experiences of fathers of children with BPD?”.

Chapter 3 Methods

The aim of this study was to explore the experiences of fathers of children with BPD. The following section begins with my relationship to the topic. It then describes the methodology used to meet this research aim, including discussion on its theoretical underpinnings and rationale for selecting this approach. Details of participants, recruitment process, ethical considerations, data collection and analysis are also outlined.

My Relationship to the Topic

It was important to reflect on my own position as the researcher and to make this explicit to the reader, particularly given the interpretative and reflexive nature of the chosen methodology. My interest in the experiences of fathers of children with BPD largely stems from my occupational experience, wherein I presently work at an organisation which supports the whānau of people with mental illness. A considerable portion of my caseload has included mothers supporting their children with BPD. Given the significant challenges I witnessed these mothers go through, I found myself wondering about the experience of the fathers, given their low representation in our service. Considering the paucity of literature on these fathers' experiences, I felt it important to seek out these fathers and tell their story.

Research Design

I used IPA, a qualitative, exploratory research design which draws on the principles of hermeneutic phenomenology. I collected qualitative data through semi-structured, individual video call interviews with participants who self-reported to meet eligibility requirements. Three participants took part, with two participants taking part in three interviews, and the third participant taking part in two. The third participant only took part in two interviews as saturation appeared to be reached by the conclusion of the second interview. The interviews ranged from approximately 45 to 90 minutes duration. These calls were recorded and transcribed with the participants' consent. I ensured trustworthiness and maintained ethical standards through various actions throughout the study.

Prior to the interviews commencing, a brief video call was scheduled with each participant to ensure participants understood the information in the participant information sheet (PIS, Appendix A) and had signed the consent form (Appendix B). Additionally, these calls served to build rapport between myself and the participants, and make the participants feel more comfortable speaking with me, such that conversation would flow more organically during the formal interviews. These calls were not recorded or transcribed, as they did not provide data and were not part of the analysis.

Qualitative Approach

Due to the absence of research related to the experiences of fathers of children with BPD, this study focused on exploring the rich accounts of these fathers' lived experiences using a qualitative methodology. Qualitative methods are ideal for exploratory research in that they allow for participants' experiences, understanding and processes of meaning making to be analysed in detail and provide opportunity for the emergence of richness and complexity in the data collected (Barker, Pistrang & Elliot, 2002).

IPA's Theoretical Foundations

IPA is characterised by its three theoretical foundations: phenomenology, the double hermeneutical process and the idiographic approach.

Phenomenological Ontology

This study adopts a phenomenological ontology, which views reality not as an objective, fixed entity, but rather one which is subjectively experienced and interpreted (Heidegger, 1962).

In the context of this research, this means that there is no singular, universal truth as to the experience of being a father to a child with BPD. Instead, fathers construct their own understanding of their experiences. Domains explored in this study, such as fatherhood and the challenges of caring for a child with BPD are not viewed as external phenomena, but as lived realities shaped by emotions, relationships and personal histories. Two fathers could encounter similar challenges regarding their child, but differ in the ways they experience and interpret them. These differing interpretations reflect the plurality of lived experience and the phenomenological nature of reality constructions. By emphasising subjectivity, this ontological stance aligns with the study's aim to explore how fathers of children with BPD make sense of their experiences, rather than aiming to identify generalisable facts about being a father to a child with BPD.

Hermeneutic Interpretive Epistemology

Given the study's phenomenological ontological stance, an interpretive epistemological stance, rooted in the hermeneutic tradition, will be adopted also. Here, knowledge is not discovered as an objective truth which will merely be measured and recorded, but rather is actively co-constructed through a dynamic interplay between participant and researcher (Pietkiewicz & Smith, 2014). This position recognises that understanding fathers' experiences is inherently mediated by language, context and the researcher's own interpretive lens.

This co-construction of meaning is best understood through the concept of the 'double hermeneutic' or as a dual interpretation process (Pietkiewicz & Smith, 2014). Participants make meaning of their world, while the researcher then attempts to decode and interpret participants' verbalisations of these meanings (Smith & Osborn, 2003). The researcher is trying to understand what an experience is like from the participants' point of view while also critically reflecting on how and why these experiences were constructed and articulated in a particular manner.

For example, if a father were to describe feeling powerless when learning of the challenges associated with one's child having BPD, the analysis aims not to take the concept at face value as a static descriptor, but instead explores how this father constructs his sense of powerlessness - is it mediated by societal expectations of fatherhood, personal guilt or difficulties navigating the mental health system? This process acknowledges that all knowledge is contextually situated and requires reflexive engagement with the researcher's own assumptions and prior knowledge. This dual interpretative process of meaning making makes the analysis richer and more comprehensive (Pietkiewicz & Smith, 2014).

Idiography

Idiography refers to the in-depth analysis of single participants and examination of the individual perspectives of these participants in their unique contexts (Larkin et al., 2006; Pietkiewicz & Smith, 2014). Idiography is best characterised as the study of specifics, rather than the study of the general, i.e. nomothetics (Larkin et al., 2006). Unlike nomothetic approaches which aim to identify universal laws, idiography focuses on specific individuals as they navigate specific situations in their lives, thus capturing the richness and complexity of how a single person makes sense of their world. The researcher also engages in sequential analysis - themes are developed within one transcript before comparing across cases (Eatough & Smith, 2017). There is thus a rejection of generalisation; participants are compared and contrasted, rather than amalgamated into a singular analytical entity (Pietkiewicz & Smith, 2014).

Selection of IPA

Interpretative Phenomenological Analysis was selected as the most appropriate methodology for this research due to being the most theoretically and practically sound means of analysing fathers' experiences of having a child with BPD. Grounded theory (Glaser & Strauss, 1967), thematic analysis (Braun & Clarke, 2012), and narrative analysis (Riessman, 2008) were considered but ultimately rejected: grounded theory was deemed inappropriate because the study sought idiographic, experiential depth rather than theory generation; thematic analysis lacked an explicit epistemological foundation and risked sacrificing IPA's idiographic focus; and narrative analysis would have prioritised narrative structure over the phenomenological immediacy of lived experience.

Unlike these methodologies, IPA's hermeneutic approach explicitly acknowledges both the participants' meaning-making processes and the researcher's interpretative engagement with these processes. This approach thus allows for the researcher to add qualitative richness to participants' expressions of experience while ensuring phenomenological fidelity (Larkin et al., 2006). The idiographic commitment of IPA also makes it an ideal methodology for the deep exploration of individual fathers' experiences before identifying patterns across participants. This research did not aim to make generalisations about a particular population, nor simply document events in these fathers lives; this research aimed to deeply explore the lived experiences of a currently un-researched population, thus making IPA an ideal methodology.

Sampling and Participants

Inclusion Criteria

Participants were recruited that met the participation criteria of: a) being the father of a child diagnosed with BPD; b) their child received a diagnosis at least two years ago; c) the father lives in New Zealand. Phenomenological research designs like IPA require a purposive criterion sampling method such as this, as it is imperative that the participants have all experienced the same phenomenon being studied (Creswell, 2007).

The study aimed to recruit approximately 3 participants. This number was selected after discussions with my supervisor due to our perception that it allowed for a balance between idiographic richness and cross-case comparison that was realistic within the time frame of the study. Smith et al. (2009) recommend this same number as an ideal sample size for a student project, and note that they now "treat n = 3 as the default size for an undergraduate or masters-level IPA study" (p. 52). Additionally, Eatough and Smith (2017) advocate for keeping sample size small and homogenous and interviewing participants several times.

Recruitment Procedures

Participants were recruited through various means including direct contact, snowballing, and online advertisement. An example email and Facebook post are available to view in Appendix C. The recruitment flyer is available to view in Appendix D. The recruitment flyer gave some brief information about the study and contained a QR code which when scanned took participants to the PIS to access the full information about participation.

Interested participants contacted me via email. I then sent them the PIS as well as the consent form to sign if they desired to move forwards. After receipt of the signed consent form, a 15-minute video call was arranged to provide participants with the opportunity to ask any questions they had about the study, go over what will be involved in the interviews, review the PIS and consent form, and generally provide a space to build rapport, as this is an important component of an IPA study (Smith et al., 2009). From here, a one-hour interview was scheduled with each participant, with subsequent interviews being booked at each interview's conclusion.

Three participants took part, with two participants taking part in three interviews, and a third participant taking part in two. The third participant only took part in two interviews as saturation appeared to be reached by the conclusion of the second interview.

Participant Demographic Information

Table 1

Participant Demographic Information

Participant pseudonym	Age	Ethnicity	Child's age	Child's gender	Approximate time since diagnosis	Other diagnoses
Leon	59	Pākehā/New Zealand European	27	Male	3 years	ADHD
Simon	70	Pākehā/New Zealand European	43	Female	2.5 years	–
Donovan	69	Pākehā/New Zealand European	38	Female	7 years	–

Note. Demographic information was self-reported

Ethical Considerations

This research was reviewed by a Massey University Research Ethics Advisor in consultation with the Research Ethics Chairs' Committee's Acting Chair and approved as low risk.

Informed Consent

All participants provided their informed consent by reading the PIS and signing the consent form. Prior to the interviews, all participants were provided an opportunity for questions. All participants were aware that they had the option to withdraw their consent from the study at any time for any reason. Informed consent was obtained from the participants for their interviews to be audio-recorded and transcribed.

Confidentiality

Confidentiality conditions were outlined in the PIS and discussed with participants in the informal video call prior to carrying out the interviews. All participants understood that all responses would remain confidential unless I held a strong belief that there was a serious risk of imminent harm or danger to either the participant or another individual, or if a serious crime had been committed. Participants understood that their signed digital consent forms would be stored for 20 years as per Section 12.5 of the General Disposal Authority for New Zealand Universities and then digitally destroyed. Participants understood that all interview data would be securely stored on a password-protected cloud server, de-identified, and that the de-identified interview transcripts would be retained for one year after the conclusion of the study and then digitally destroyed. Finally, participants understood that no identifiable data would be used during the analysis or write-up of the thesis.

Potential Distress

The potential for the participating fathers to encounter a degree of distress or negative emotionality when discussing their experiences was considered for this study, including through discussions with my supervisor and communications with a Research Ethics Advisor. Ultimately, we believed that the questions were appropriate for the study and not significantly upsetting to consider. The PIS contained the contact information for numerous relevant support organisations that participants were able to contact in the event that they felt they required support after the conclusion of any of the interviews.

To support the participants during the interview process, they were able to choose whether or not to answer any given question, take a short break if required, or end the interview early. Ultimately, no interview finished early and the participants largely did not require support during the interviews.

At the conclusion of each interview, we ended the formal interview process and briefly chatted to check in on how the participants were feeling and organised a time for the next interview. At the conclusion of the final interview, participants were thanked for their time, debriefed (see Appendix E), and given the opportunity to ask any questions and provide feedback. Participants were also offered a $50 Prezzy card for their participation. One participant declined this, while the other two accepted.

Data Collection

Before formal interviews began, an informal video call was held with each participant to build rapport and ease entry into the interview relationship (Smith et al., 2009). Semi-structured interviews were then used to collect data, as this flexible format enables participants to shape the discussion and is considered the exemplary method for IPA (Smith & Osborne, 2003). This approach facilitated conversational depth while allowing unanticipated topics to emerge, consistent with IPA's aim to "enter, as far as possible, the psychological and social world of the respondent" (Smith & Osborne, 2003, p. 59).

The interview schedule (Appendix F) was developed iteratively in consultation with my supervisor and followed established guidelines for high-quality IPA questioning: open-ended phrasing, avoidance of jargon or leading language, and funnelling from general to specific topics (Smith & Osborne, 2003). Key domains included relationships, self-image and fatherhood, coping, and support. Interviews were loosely structured around three temporal phases - pre-, during-, and post-diagnosis.

Procedure

All interviews were completed via video-call. The interviews lasted approximately 45 to 90 minutes each, were recorded and subsequently transcribed. I kept a research diary (Appendix G) to consider what influence my experience and feelings before, during and after each interview may have had on the interviews. This served as a means for me to engage in continual processes of reflexivity, allowing me to explicitly reflect on my own biases, assumptions and values and thus identify my contribution to the interpretative process (Larkin & Thompson, 2012).

Data Management

All collected data, including consent forms, was stored on a two factor authentication, password-protected cloud service. As per Section 12.5 of the General Disposal Authority for New Zealand Universities, the scanned consent forms will be kept for 20 years and then digitally destroyed. The de-identified interview transcripts will be retained for one year after the conclusion of the study and then digitally destroyed.

Data Analysis

Smith and Osborne (2003) note that IPA "is not a prescriptive methodology [...] it is there to be adapted by researchers, who will have their own personal way of working" (p. 67). I thus considered it important to consult multiple texts before beginning the analysis process, to ensure that different approaches were considered. Three key texts were eventually used to inform the IPA analysis process for this study (Larkin & Thompson, 2012; Smith & Osborne, 2003; Smith et al., 2009).

Case-By-Case Analysis

Given IPA's idiographic nature, analysis began at the individual level. Beginning with just the first participant, their transcript was read several times, with the intention of being as familiar as possible with their account. During this stage, I engaged in 'open' or 'free' coding, wherein I allowed myself to annotate the transcript in any way that seemed immediately appropriate. For example, I allowed myself to write my emotional reactions to the participant's responses, my feelings about how the interview went, initial ideas about themes or any relevant psychological concepts that came to mind. This allowed me to identify and consider the influence of my preconceptions so that I could then proceed with a more systematic focus (Larkin & Thompson, 2012). An example of this process can be seen in Appendix H.

From here, I set aside the free-coded transcript and started with a fresh one. I then formatted each transcript to include two columns on either side of each transcript's text. In the left hand column I engaged in phenomenological coding, whereby anything "interesting or significant" said by the participants was annotated - a process which has "no rules about what is commented upon" (Smith & Osborn, 2003, p. 67). Then, in the right column, I identified emerging themes in the participant's account. This involved creating thematic units of meaning by condensing the phenomenological coding data, while retaining its quality and remaining close to the participant's own language (Smith et al., 2009). An example of this process can be seen in Appendix I.

These emerging themes were then conceptually clustered together. From here, superordinate themes were created which represented the highest possible degree of abstraction of the clustered emergent themes while still remaining grounded in their shared meaning. For each superordinate theme, representational extracts and quotes from the transcript were chosen to ensure that the themes were grounded in the participant's own words and experiences. These extracts and quotes were also used to assist in the write-up of the results. An example of the process of developing emergent themes and clustering to form superordinate themes can be seen in Appendix J. This entire case-by-case analysis process was then repeated for each participant.

Cross-Case Analysis

All participants' superordinate themes were then analysed to identify convergences and divergences across the data set to form a final set of superordinate and subordinate themes for the entire data set. Participants' transcripts were revisited during this process to ensure that the superordinate group level themes remained grounded in the participants' experiences. A table was then composed illustrating the superordinate and subordinate themes for the whole data set (see Appendix K). This table contained an excerpt from each participant's transcript which illustrated the themes. A document was created collating each participants' quotes that pertained to the final themes, and was used as the basis for writing up the results.

Extracts and verbatim quotes from the interviews were used to aid the reporting of my analysis and illustration of the themes, as well as support my interpretative analysis' validity. All original names have been changed to pseudonyms. To aid the readability of any interview extracts, repeated words have been reduced to a single occurrence of the word (eg. "but- but" changed to "but"). Any removed material is indicated by ellipses within square brackets (eg. [...]). Any material added by myself to provide context to an extract is marked with text inside of square brackets (eg. [She said that]). Otherwise, all participant quotes are presented verbatim, with minor grammatical errors retained to preserve authenticity.

Chapter 4 Results

This chapter reports the outcomes of the analysis of several interviews with three fathers of children with BPD. The following four superordinate themes emerged from the analysis: Powerlessness and the Limits of Fatherhood; Commitment and Connection (or Lack Thereof); Coping with the Ongoing Burden; and Making Sense of BPD and Renarrating Fatherhood

In line with the interpretative nature of IPA, I recognise that my own meaning making played an active role in shaping the interpretation of participants' experiences and the resultant findings. These themes thus offer one possible account and construction of the experiences of fathers of children with BPD based on my data. This account was done so earnestly and rigorously in an attempt to communicate the experience of these fathers as genuinely as possible.

Given the small sample size and the highly idiosyncratic nature of each father's experience, the results are reported in such a way where each subordinate theme respectively pertains to a particular father's experience in relation to the superordinate theme. For example, the first subtheme, Theme 1.1: Frustrated Agency, refers to Leon's experience in relation to the superordinate theme, Powerlessness and The Limits of Fatherhood. This approach allowed for each father's unique experience to be communicated in depth rather than diluted through amalgamation with the other fathers' experiences relative to each subtheme. This was done in an effort to reject generalisation and to ensure that participants are compared and contrasted, rather than amalgamated into a singular analytical entity (Pietkiewicz & Smith, 2014).

Table 2 below contains a summary of the superordinate and corresponding subordinate themes. A comprehensive account of each of these follows the table.

Table 2

Superordinate and Subordinate Themes

Superordinate themes	Subordinate themes
Powerlessness and the limits of fatherhood	Frustrated agency (Leon)
	Feeling useless and incapable (Simon)
	Learning to support, not solve (Donovan)
Commitment and connection (or lack thereof)	Unwavering commitment despite rejection (Leon)
	Rediscovering connection (Simon)
	A united front (Donovan)
Coping with the ongoing burden	Struggling to cope (Leon)
	From distraction to engagement (Simon)
	Families need support too (Donovan)
Making sense of BPD and renarrating fatherhood	Fatherhood in name only (Leon)
	Reconstructing fatherhood through connection (Simon)
	A different approach (Donovan)

Theme 1: Powerlessness and the Limits of Fatherhood

This theme captures how each of the fathers experienced a sense of powerlessness during their experience of supporting their child. In general, these fathers had rather idiosyncratic experiences and convergence tended to require higher level abstraction to find. However, experiencing powerlessness was universal and pervasive. The powerlessness experienced by these fathers was rooted in their experience of being unable to directly change their child's situation and generally experiencing a lack of control and agency.

Various factors ranging from the MHS, difficulties in co-parenting a child with BPD after separation, a lack of skills, relational dynamics and the behavioural complexities of BPD all contributed to these experiences of limited agency and powerlessness. For Simon and Donovan, these feelings subsided as their relationships with their children developed over time, while for Leon, these feelings continued to be pervasive and distressing.

Theme 1.1: Frustrated Agency (Leon)

Leon's experience was defined by a sense of impotency and restricted agency at every turn. Leon reported feeling excluded and undermined by the MHS, his ex-wife and his son, Andy. This resulted in Leon feeling immensely frustrated and completely stripped of agency. He experienced an inability to have a positive effect on Andy's life, despite wishing for nothing more and remaining deeply committed to him. Leon thus felt powerless, unable to be the father he wished to be for his son.

For the first few years of Andy's involvement with the MHS, Leon reported intense frustrations with the MHS' tendency to defer to his ex-wife regarding communications pertaining to Andy, as well as his ex-wife's subsequent handling of this information. Leon described his ex-wife as "*a filter between me and the mental health system*", wherein he would not be contacted directly by the MHS, and thus be reliant on his ex-wife to disclose information pertaining to their son. Leon reported that typically "*she wasn't sharing it, and I couldn't hear it*". Leon's challenging relationship with his ex-wife and her non-disclosure of information pertaining to Andy thus compounded the limited agency he experienced in his dealings with the MHS.

Leon would attempt to contact Andy's care team himself to find out what was said to his ex-wife, however this was largely ineffective as "*because in their mind, they've already spoke to* *one of the parents*". Leon felt that "*it's almost like you've got one chip to use. And if you use that chip, that's it. And my ex would use the chip, and I wouldn't have the ability to find out stuff. And that was really, really hard*". Despite Leon's best efforts to obtain information from his ex-wife and the MHS, he was unable to do so. Leon thus found himself perpetually frustrated, lost and shut out, unable to be involved as a father in his son's care: "*So I was kind of behind a barrier, a shield, kind of thing that I couldn't penetrate, really*".

This exclusion extended to his relationship with Andy. Leon and Andy have always had a difficult relationship, with Leon feeling that Andy greatly prefers his mother, however this became especially pronounced once Andy first became acutely unwell. When Andy was first hospitalised, Leon recalled that:

> *He wouldn't even allow me to go in hospital, so the doctors wouldn't let me go into the hospital. [...] I'd stand outside and I'd look at him on the other side of the door and just stand there. And my heart was broken. I just wanted to be with him and he wouldn't let me.*

Even when Leon was able to be physically present in the hospital with his son, he was excluded and powerless. Leon also expressed frustration with the lack of accountability from the MHS. Given that Leon himself was not able to do anything personally to improve Andy's condition while he was hospitalised, he had to place faith in Andy's care team to take action to help his son. Unfortunately, Leon felt that this faith was to no avail.

> *So my experience is there's a lot of talk, but not actual action, and it's really hard to push through that, because you kind of, I don't know, men want to have- they want to fix things. They want to get things done, and it's so frustrating when people's word is not kept. So I found that really difficult.*

Furthermore, the MHS' deference to Andy's mother was so significant that even when Leon was listed as his son's emergency contact, the hospital still called Andy's mother:

> *I must admit, I lost it. I got angry with the nurse. I said, why was I not rung by the psychiatrist? And he got all defensive. "Well, you know, he is his mother's son." Yeah, but I'm the next of kin.*

Leon reported that he "*never got the intimacy of being first hand with the doctors. Because you're a split relationship, they always go to one person*". When I asked Leon what he felt would have been helpful in his interactions with the MHS, he said that "*I wanted to see that I'm an equal parent and that I deserve to be spoken to and to understand what's going on*", clearly highlighting the exclusion underpinning his experience. Leon also felt that Andy's care team's lack of engagement with him was detrimental to Andy's prognosis as it led to a very limited understanding of his condition:

> *They're not seeing what we're seeing for [...] seven days a week for months on end. A very short period, and they have to come up with their understanding. And if we'd only had the space to engage, to tease out the behaviour and the patterns and all that sort of stuff, I feel like a better understanding would come about.*

The relational difficulties characteristic of BPD also made it very difficult for Leon to feel like his actions advocating for his son to get into a DBT program would bring the desired results: "*He constantly kept burning all his bridges to the point where his psychologist could no longer work with him*". Additionally, Andy lacked insight into his unwellness, resulting in a "*pinging and ponging going on between the mental health system in the community, the mental health system in the hospital situation, and they're never two coming together*". Andy would reach a state of acute unwellness wherein he would be hospitalised under a Compulsory

Treatment Order, and thus have to take medication. Leon notes that "*he kind of would come right with medication, but then he'd come off still denying anything's wrong with himself, and then come off medication and eventually fall apart*" and end up back in hospital.

Leon acknowledged the limits of his control and the powerlessness he felt as a result of his son's lack of insight into his unwellness:

> *I guess at the end of the day, you can want these things as much as you want. You know, that old adage, you can lead a horse to water. It's very much like that, because if the person doesn't see that they're unwell, well, you can get them on the list for DBT programme and all that sort of stuff, but it ain't going to work.*

Leon was the only participant whose child experienced a lack of insight into their condition, which Leon believed was a major factor behind Andy's cyclical crises and inability to engage in effective treatment. This compounded Leon's sense of powerlessness and caused him to become jaded, believing that there was nothing he nor anyone else could do to help his son. The other participants' children were able to effectively engage in treatment and communicate with their fathers about their experiences, thus providing a means for collaborative problem-solving.

Theme 1.2: Feeling Useless and Incapable (Simon)

Simon struggled greatly with coming to terms with the limits of his agency as a father of a child with BPD. His immediate inclination was to try to fix his daughter's struggles and to improve her situation, however his realisation that he was unable to do so resulted in great psychological strain. Simon also only found out about his daughter's mental health struggles fairly recently (roughly two-to-three years ago), causing Simon to feel like "*a hopeless dad*" for not having been able to be there with her more throughout her life and support her.

Like Leon, Simon had a challenging relationship with his ex-wife and felt that she withheld important information from him relating to their daughter. Simon had separated from the mother of his children when they were young. After the divorce settlement was completed, Simon was only able to "*end up only seeing the girls every second weekend, or even less, you know. The school holidays*." Simon thus was largely unaware of his daughter, Kathy's, struggles with BPD before she was diagnosed: "*It was really hard, yeah, because you didn't have them all the time. You didn't see them every day. So, you don't know what's going on. What do you do?*" Simon would only find out Kathy was struggling by receiving a phone call from Kathy's sister, Diane, indicating that "*Kathy is not doing well at the moment*".

The physical distance between Simon and Kathy and their lack of quality time together meant that Simon experienced periods of anxiety whenever he would hear that Kathy was not doing well as he was unable to be there to support her: "*That's the main thing in my head is what can I do? Yeah. [...] I'd get a little bit anxious about it, you know? Yeah. Until I could see her personally*."

In addition to the limited contact that Simon had with Kathy when she was younger, Simon felt that much of Kathy's struggles were kept from him by Kathy's mother. Simon's experience here was similar to Leon's, wherein their ex-partners controlled the disclosure of information relating to their child's unwellness, thus leaving the fathers largely in the dark. Simon notes that "*her mother did not give me any information, just kept it all sort of hushety-hush. [...] As if it was something not serious, not a problem or whatever*." This resulted in Simon feeling shocked upon hearing of Kathy's diagnosis and resentful towards his ex-wife for keeping this information from him. He then felt guilty and incapable for not knowing Kathy was experiencing this and also for not being able to directly help her. Simon describes his experience of Kathy disclosing her BPD diagnosis below:

> *Simon: It was horrible. [...] And I just have to listen because [...] I just had no idea that this was like this, you know? It just explodes. And yeah, I just felt, okay, like, god… Yeah. It's not as if I could go throw the switch and fix it. You know? [...] Or pull it apart and repair it. Yeah. So that's the horrible part of it. Yeah.*
>
> *Interviewer: Not being able to sort of have any effect on it yourself, you mean? Not being able to fix or change anything?*
>
> *Simon: Yes. You know, make things better. Put a plaster on it. [...] That's how I felt. Yeah. Worthless, incapable and horrible. Yeah. Horrible feelings.*

After hearing of his daughter's diagnosis, Simon described frequent ruminations of feeling "*hopeless*", "*incapable*", "*useless*" and like "*a big dummy*". These feelings were related to Simon wanting to directly help fix his daughter's problems: "*What stands out to me the most is, I felt I was useless, you know? [...] What can I do? Or how can I help*?". The inability to directly affect change on his daughter's condition and struggles resulted in great psychological pain for Simon, as he felt powerless in his capacity to care for his daughter. Over time, Simon has worked through many of these feelings and found means to cope with them, which will be discussed in Theme 3.2.

Theme 1.3: Learning to Support, Not Solve (Donovan)

Much like Simon, Donovan's disposition is that of a problem solver. Donovan described a long and challenging journey towards accepting that he was unable to directly influence his daughter's struggles and that he needed to learn how to support his daughter, Ava, and not solve her problems.

Donovan described himself as solutions-focused, or someone who "*certainly has a dislike for where systems and processes and relationships and so on are suboptimal*". Earlier on in his journey supporting Ava, this led him to focus on ways to improve particular symptoms when she would share her struggles and frustrations, which routinely resulted in her feeling unheard and invalidated: "*the first thing you notice are the symptoms and you go for that. And with somebody with BPD, what a great way to make the situation worse*." Donovan spoke of "*wanting to do everything I could do to help improve the life that Ava was and is encountering*", but noted that this produced counterproductive results, as "*the fix-it-ness, the protectiveness and so on that was in there meant that I really wasn't playing a role that could have been as good as what it could be*".

Donovan reported that both Ava and his wife, Claire, have many times over the years expressed that he has "*a tendency to not really listen, but [be] constantly looking for solutions. And that was not something that they necessarily enjoyed or found all that helpful. They found it frustrating*." What they were looking for was "*somebody that would listen [...] to what they were having to deal with without the father interrupting the story in terms of seeking solutions*." It took Donovan a long time to understand that he was not able to solve his daughter's problems and that she is the only one that can do this:

> *The thing with the condition and with Ava [...] is you can't do things for them. She can't improve, she can't do well unless she's got the confidence and the wherewithal to be able to do it. To try and do things for them will be very short term in terms of any outcome, in terms of improvement.*

Particularly since Ava received her BPD diagnosis, Donovan has come to understand that Ava's experience will be chronically challenging. He cannot make the BPD go away: "*there's no magic bullet*". He can just support her while she lives with it:

> *With BPD, it's really trying to understand the problem, and it's not- you can't solve it. It's there. It's not a solvable one. The best result you can expect is not that they become normal. Their condition is, they have it, they'll always have it. It's a matter of being able to get them to be in a position where they can make the best that they can of themselves.*

Through extensive effort and "*some good sessions where we sat down and the tears flowed*", Donovan has worked to adapt his approach to supporting his daughter to incorporate more of the active listening and validation skills that his daughter desired: "*And it wasn't answers. It was that validation. It was to have an understanding*". He was able to move into a place of acceptance wherein he cannot personally solve his daughter's challenges, but he can support her to improve her own life: "*It's taken quite a while to get to that stage. In terms of accepting that you can't change. You can- it's just creating the environment for her to be able to change*."

Theme 2: Commitment and Connection (or Lack Thereof)

This theme illustrates the complex interplay between the fathers' commitment to their children and the quality of relational connection with their child. All three fathers were deeply committed to their children, however the degree to which they felt connected with their child and the ways in which this connection was achieved (or not) differed. Two of the fathers felt that their connection with their child strengthened over the course of their journey, while the other experienced a degradation of an already challenging relationship.

Theme 2.1: Unwavering Commitment Despite Rejection (Leon)

Leon’s relationship with his son was always challenging. After separating from Andy’s mother when Andy was seven, Leon had limited custody. After the separation, Leon found himself feeling “*like I was being rejected*”. When Leon would “*have him on the weekend, he'd just cry*”. This dynamic continued over the years as Andy grew older, with Leon being desperate to develop a quality relationship with his son, but continually feeling rejected:

> *You feel like as a father, your own son doesn't want to be with you. [...] I just couldn't connect. So, it's always kind of been like that all the way through. Not for me not trying or wanting to be there for him.*

As Andy became older and the symptoms of his BPD began to manifest more acutely, Leon found himself becoming the victim of intense verbal abuse from his son: “*He says, “come here, I'm going to punch your face in. I wish I'd punched your face in while you're here. And I'll beat you up and pummel you in”. And he just abused, abused, abused*.” Progressively, “*the times of us having a conversation that was two-way became less and less and less. So it became a one-way relationship, in that every time I spoke to him, it was him raging. And I couldn't say anything*”.

While this abuse was incredibly traumatic for Leon, he found that his unwavering commitment to Andy and his fundamental love for him kept him working to support his son. Leon viewed Andy’s abusive behaviour as a product of his unwellness, which enabled him to tolerate it: “*I had to still just hang in there and think, he's not well, he's not well. Hang in there*.” Leon describes the struggle to reconcile the compassion he felt for Andy by viewing his behaviour as a symptom of his unwellness with the immense toll the abuse was taking on Leon’s wellbeing: “*You can't see it as being him, but it is him, and that's the difficult thing. [...] How do* *you offer grace and all those sorts of things to people like that? Stay in a relationship, but getting abused*."

Leon recounted his struggles with establishing boundaries to safeguard his wellbeing, and reconciling that concept with the unbreakable commitment he feels towards supporting Andy. The sheer psychological toll of the abuse that Leon faced is immediately evident in his accounts of his experience. The quote below illustrates the extent to which Leon's devotion to Andy was able to carry him through incredibly traumatic abusive behaviour from his son.

> *I've been muddling all my way. I've got to keep connected. I've got to keep the bridge open. I've got to take the abuse, take it all, just face up to it again and again and again. He rings, you answer. You face it. You don't get to talk. You don't get to help. You just get attacked verbally, demoralised, pulled down to the scummiest person on the earth. Your life's not worth living. That's what you're made to feel like. "You're a piece of shit. [...] You would do this if you were my dad. You would do this. That's what dads do."*

At one stage, Andy threatened his mother with a weapon, resulting in a restraining order which left Andy unable to contact his mother while the restraining order lasted. During this period, Andy remained acutely unwell, bouncing between the justice system and the hospital, and Leon was the only person able (and willing) to support Andy. Leon recalls the resolute commitment he felt towards supporting his son despite the abuse he experienced, as without Leon, his son would have nobody:

> *You're overwhelmed by the pain and the hurt, the belittling, the metaphoric punches that were never ending, never stopping. It didn't stop. And I stayed there. I stood there. And I held firm. But I took so much, so much shit. [...] I was the only one there for him. At the end, I was the only one.*

Leon hung in there also due to "*hoping one day our relationship would somehow waken up*." After the restraining order between Andy and his mother ended, Andy went back to his mother and has essentially ignored Leon since, causing Leon to feel immensely hurt and rejected: "*I've just journeyed through [...] hell for the last two years and you haven't even thought to contact me and reach out, no nothing. Am I really nothing to you*?" Leon reported feeling "*rejected*" and that Andy doesn't "*really [want] me as his father*". Leon felt that Andy only engaged with him because "*he had no choice but to reach out to me when his mother had him arrested*", and most of that engagement with Leon was just a "*minefield of abuse*". Leon described currently processing feelings of "*anger*" due to feeling like he "*was just used*" by his son, which "*really, really hurts*" him.

Due to this experience, Leon ultimately feels that he does not actually really have a true relationship with his son. Leon outlines his perspective on their relationship below, highlighting its unfair, one-sided, damaging nature:

> *But I don't have a relationship. We don't have the relationship. And it's not for me wanting. It's really hard to have a relationship with someone that becomes abusive, and that uses. It's not reciprocal. A relationship should be reciprocal, and, you know, it requires other people saying, hey, how are you feeling? How are you going? All that sort of stuff, you know, it's a two-way thing, but it's not like that with my son. It's just one way, and it's one way to my detriment, downhill.*

Theme 2.2: Rediscovering Connection (Simon)

Simon's daughter's BPD diagnosis opened the doors for renewed connection and the facilitation of deeper communication, leading to a revitalised, enriched relationship between father and daughter. Simon was always deeply committed to Kathy, however the barrier created by his limited custody when she was younger created distance between the two which persisted into adulthood. Due to this, he felt they were never able to truly connect:

> *Simon: Yeah, so father-daughter relationship was, well, pretty vague, really. [...] Because we didn't have that time, you know, didn't have that everyday stuff.*
>
> *Interviewer: Do you mean by that, that it never got sort of deep? Because you didn't have time for it to develop so much?*
>
> *Simon: That's dead right, yeah, that's it.*

Simon described feeling like "*a hopeless dad*" during this time and did not know what to do: "*I just felt incapable. I felt hopeless. Yeah, I just couldn't manage it.*" Simon described being aware that himself and his daughter were "*getting disconnected*" over time due to their custody arrangement, yet felt powerless to change the situation. Simon lamented the lost opportunity to develop the relationship he sought with his daughter in her younger years, saying that "*there's a lot of memories gone*".

As she grew older and became an adult, this disconnection persisted, as Simon would "*only hear from her now and again*". That is, until she disclosed that she had been diagnosed with BPD. This disclosure acted as a catalyst for their reconnection and a "*huge step*" which resulted in them engaging in deep, vulnerable communication with each other which fostered the beginning of a new relationship. Simon discusses this change below:

> *Simon: So, now it's sort of like, okay, I'm sort of in a spot where I can be there for her and [...] it works.*
>
> *Interviewer: Yeah. Do you feel like your relationship has sort of improved after that conversation, in a sense then?*

> *Simon: Well, of course it has, because you're communicating about things that were not said previously. You get what I mean? [...] Nothing's been covered up. It's free and open.*

This initial conversation led to them bonding more than ever before, with the lines of communication remaining open since. Simon now felt that their relationship was "*very good, actually, and improving*" and is "*at a point where [he's] happy with*" the quality of their relationship, after feeling mournful about it for so much of his life. After a long journey of "*try[ing] and striv[ing] for that*" and "*want[ing] that connection*" he finally felt that he had achieved it.

Theme 2.3: A United Front (Donovan)

Like the other fathers, Donovan remained incredibly committed to supporting his daughter throughout the entirety of her journey with BPD. Donovan differed from the other fathers though in that he remained with the mother of his daughter. Donovan and his wife, Claire, have worked in a collaborative and considered manner with their approach to parenting Ava, as it was apparent from a young age that she was a challenging child that required a tactful approach to parenting: "*Basically, since she was very young, there was a lot to be worked on, because she didn't respond like so many people do*." Donovan and Claire did not want to make Ava feel like the 'bad' child and her sister, Kimberley, the 'good' child due to their difference in demeanour and behaviour: "*We had to be careful that it wasn't always positive for Kimberley, and Ava, the naughty one*."

They attended a positive parenting course, which promoted parenting based on positive reinforcement and teaching over punitive approaches. Donovan and Claire found this course had "*a significant impact on both of us*" and was "*a magnificent way*" to parent Ava. They would often discuss their approach together and tweak this depending on the feedback of the other: "*We could talk about it and look at, how could we do it in a positive way?*".

This collaborative approach to finding the most effective ways to foster wellbeing in Ava has continued to the present day (at the time of the interview) for Donovan and Claire. As Ava grew older and her struggles became greater and more wide-reaching, "*it was apparent that this wasn't something which was a childhood issue. It is a lifetime challenge that she has to deal with, and as a consequence, the family has to deal with*." Donovan clearly outlines his family's fundamental commitment to supporting Ava: "*It was a situation where we had somebody that just required a lot more of our time and commitment. And we had no choice. If we were to make a choice, we were there*". Given their dedication to caring for and supporting Ava, Donovan and Claire didn't view providing the increased support required as a choice - it was their duty as parents. Donovan attributed the quality and strength of his relationship with Ava to the uniform commitment of his family to supporting both her and each other over the years.

Donovan discussed the significant financial burden of BPD, in that Ava struggled with managing a budget, had a tendency to accumulate credit card debt, struggled to maintain employment and also struggled with co-habitation: "*She can't function in a multi-person flat. The condition that she's got, having others around, and particularly in a confined space, [...] she finds it very difficult to survive and operate*."

This resulted in several instances where Donovan and Claire had to provide financial assistance, such as through paying off credit card debt or buying her an apartment. Donovan noted though that these were not gifts or acts of financial rescue. "*She's got to pay rent*" for the apartment she lives in, and "*it's all recorded, so that in our estate, when we pass on, [...] the* *money that has been spent on Ava and sorting out credit cards at some stage and subsidising in the accommodation that she's at and so on is sorted out*."

Donovan felt that for Ava to be able to maintain employment or manage a budget, having an environment wherein she feels "*that she's got that feeling of wellness and then can operate to the best of her ability*" is imperative. He believed this was extremely challenging for her to do in a flat situation, and thus the purchase of the apartment provided her the foundation to then flourish as a person and address the other aforementioned concerns. Donovan stated that things have dramatically improved for Ava since she has had her own accommodation.

Donovan noted a recent perspective shift, wherein he previously saw Ava as being privileged due to having incredibly committed and supportive parents. He now however views himself as privileged, as he feels that Ava's life would be substantially worse without the aforementioned financial assistance, and thus his life also would be substantially worse:

> *If I wasn't in a position where I could do this for her financially, it would be unbelievably difficult for others. So, in saying that she's privileged, [...] I'm from an advantaged position in some respects. Advantage might be the wrong way of putting it, but I'm in a position that some others won't be in and to be able to give the support that she needs so that she's got that feeling of wellness and then can operate to the best of her ability.*

Donovan stated that his family act as a united front, wherein they are all fundamentally committed to supporting one another. This means that all members of his family support Ava extensively, however they also support one another to fulfill this role: "*Ava's got a team of three that generally are very united. And if they're not, the discussion will go on between us*." They also engage in focused conversations of constructive criticism, wherein they assess what each other are doing well or not so well, and help each other to develop facets of their respective support styles:

> *Well, the family's always been close. This has ensured that it has stayed close because if there's some reaction or response from any one of the three of us that's sort of not necessarily out of line, but needs to be aware of a concern that needs support or to be addressed, it happens. [...] The biggest challenge is knowing when to do so and structuring it so that others don't become defensive or feel that they're being negatively targeted or whatever. And because if there are issues, they have to- they need to be discussed.*

Donovan noted that his family is a "*nuclear family in its most sort of clinical sense*" as "*neither Ava nor Kimberley have partners. So, our family is the four. There's no kids or grandkids*." In Donovan's eyes, that has meant that the family bond has remained "*strong*" and had more resources available to support one another. While Donovan still felt their experience has been "*challenging as hell*", he believed that it would be much more challenging if "*there were son-in-laws or partners [or] children involved*", as "*the time and the attention and everything else available as part of the unit operating is then sort of diluted to an extent*". Donovan described the amount of support that Ava requires as comparable to "*half a dozen grandkids rolled into one*", and thus not having "*the distraction of grandkids*" has "*enabled us to focus more on Ava*" without burning out.

Donovan also reflected that despite his other daughter, Kimberley, being an immense support to Ava - as well as supportive of both himself and Claire - it is a difficult balance. Donovan and Claire do not want to overly burden Kimberley with the emotional burden of their own experience, nor do they want her to sacrifice aspects of her own life and wellbeing to support Ava:

> *We don't like to sort of drag her into it, but she is just fundamentally part of it. But in terms of the anxiousness or the duress that we feel- or duress isn't the right word, but it's something that Claire and I work through and don't want to burden, if you like, Kimberley. Kimberley has got her own life to live without always having to become part of the process that we're going through in terms of Ava.*

Theme 3: Coping with the Ongoing Burden

This theme captures sentiments expressed by fathers in the study relating to coping with the ongoing burden of supporting their child with BPD. The fathers here highlight the intense challenges of supporting their child and the impact of these on their physical and psychological wellbeing. Leon discusses his continued struggle with the impacts of these challenges and his efforts to overcome these; Simon discusses the evolution of his coping strategies; and Donovan discusses gaps in support available for family members of individuals with BPD.

Theme 3.1: Struggling to Cope (Leon)

Throughout his journey supporting his son, Leon felt continually rejected, which came with great pain. The emotional toll of chronic, violent verbal abuse on top of this rejection ultimately led Leon to a breaking point wherein he decided that he needed to quit his job, break off communication from his ex-wife completely, and establish boundaries between himself and his son: "*I just got ground down into the ground so badly. I had to leave work. I had to get away. I had to look after myself because I was dying, physically dying*." These boundaries required literal physical boundary setting; Leon moved to a remote rural area to live alone in a cabin and recover:

> *This actually forced [retirement] on me. Because I was broken. He broke me. He broke me and I'm trying to recover. And I figured I'll come down to here [...] five hours away from my son. I wanted to put distance between us.*

Leon felt like his life was more peaceful in the sense that the abuse was no longer continuing due to the boundaries that he put in place, however he also continued to grapple with the guilt of leaving: "*Those are the voices that sometimes come in at night, you know, are you being selfish, not working, leaving*". Leon also described "*find[ing] it difficult to reconcile*" the desire to reach out to his son, while knowing that he needs to maintain distance between himself and his son for the sake of his own wellbeing: "*I'm still working through this, [...] but it's almost like I have to cut my son off for my own health and wellbeing*." Leon had continued "*doing therapy, working through stuff*" in an attempt to work through the emotional toll of this experience, but still felt that after such a prolonged, traumatic and damaging experience, "*I just don't feel like I have anything left in me. I don't know what makes that come back*".

Theme 3.2: From Distraction to Engagement (Simon)

Simon originally used distraction to manage the anxiety he experienced relating to his support role, but found more effective, adaptive coping mechanisms, primarily through open communication with his daughter. Simon never expressed any negative sentiment towards Kathy nor described his role as burdensome. The emotional burden that Simon described related to the anxiety and distress that he experienced as a result of the helplessness and uselessness he felt when he was not able to be with Kathy to support her, or when he felt he did not know how to support her in the ways she needed.

Prior to learning of Kathy's diagnosis, but after hearing from her or his other daughter that she was struggling, Simon would experience strong surges of anxiety until he was able to physically see her and support her: "*It would just go up and down, up and down, until I could go down to see them*". He found that he would need to distract himself by "*doing something*" and "*getting on with stuff*" until he was able to see her, "*not sitting around going um, um, um*." After first learning of Kathy's diagnosis, Simon experienced intense anxiety and rumination as a result of his feelings of inadequacy and hopelessness: "*Your brain would get to a point where it would stop and then go backwards again*".

Simon described himself as a pretty closed-off, introverted person who finds it difficult to share his struggles with other people. Interestingly though, Simon notes that it was not necessarily that he did not want to share these aspects of himself with others, but rather that he did not feel like he had people in his life that he trusted sufficiently to do so:

> *Interviewer: Who do you feel like outside of your kids has been able to support you when you've been having a hard time?*
>
> *Simon: No, I dealt with it myself. Nobody, really.*
>
> *Interviewer: Would you have wanted that or do you prefer to deal with it yourself?*
>
> *Simon: Well, it's a matter of trusting somebody, isn't it? [...] It's just the whole thing- and as soon as you open yourself up to somebody else, you're going to have to be really, really close to do that. [...] You make yourself vulnerable. Yeah, so nah, I just kept everything locked up.*

He largely attributes this to the era in which he was raised:

> *But I grew up in a generation where, you know, people kept to themselves pretty much, and if you had- well, especially, you know, if you were a male, or whatever, and you were having a bit of a problem or whatever in your life, and the rest of it, there was medication for it, and it was called a concrete pill. I'm not joking.*

Additionally, Simon attributes his lack of trust of others to masculine social norms acting as a barrier to feeling safe disclosing his struggles:

> *When you get a group of males together, you start talking about manly things, I suppose, aye. Yeah. And it wouldn't go much further than that, would it? [...] If you did start talking about something, "oh, you know I'm having a bit of a problem", or whatever, a lot of people weren't interested.*

Given that Simon didn't have anyone to talk to about his anxieties, he originally coped through "*not sitting around procrastinating. Just doing stuff*" such as getting involved in activities, trying to stay active, distracting himself, and getting out into nature. Doing so helped Simon to get his anxiety to a manageable place, wherein he felt he had some degree of control over it: "*It would knock it on the head as far as like, whack it right down to sort of virtually, yep, I can handle this*." However, this relief was often short-lived and the anxiety or, "*the big rush*", would end up returning with time as its cause was not being addressed.

The most significant improvement to Simon's previous struggles came from open conversations with his daughter wherein they were both honest and vulnerable with each other: "*I felt I was useless, you know? Just, you know, not like- what can I do? Or how can I help? Yeah. But that's gone now. It's like, yeah, because we are communicating really good.*" Simon specifically attributed his newfound relationship dynamic with his daughter as being the factor which reduced the struggles he previously found challenging to cope with:

> *Interviewer: Is that what you feel got rid of that feeling? Just having better communication with Kathy got rid of that feeling of not being able to help or do anything?*
>
> *Simon: Yeah. Yes. Absolutely.*

Simon felt they have now created a mutually-supportive relationship which has helped to greatly alleviate the mental distress he felt. Simon describes their relationship now as "*father and daughter helping each other*". While getting to this stage was "*quite an effort*", Simon truly now feels "*it's working*".

Theme 3.3: Families Need Support Too (Donovan)

While Donovan felt that he and his family have generally coped well with their situation, he notes that support specifically for themselves would have been incredibly beneficial on top of the support that Ava received.

Donovan notes that due to the strength of their family unit and their unwavering commitment both to Ava and one another, his family have largely coped well. No one bore the burden in isolation, and they had one another to speak to about their struggles: "*we're working well as a family*". However, Donovan noted that there was a lot of trial and error in the years leading to the present with regards to how best to support Ava.

As discussed in theme 1.3, Donovan found it incredibly difficult to transition from his solutions-focused nature to the support style that Ava needs. He thus had to develop many skills that were new to him, such as active listening and validation. While Donovan was eventually able to develop these skills, it took a long time to do so, and a lot of 'getting it wrong', which resulted in relational strain within the family.

When Ava received her diagnosis for BPD, Donovan reported some guilt regarding not proactively seeking out information about the condition. He reflected that at the time it felt like "*just too big an exercise, too complicated*", and he "*didn't find a way of [...] finding quality data that I could use*". Also, given that Ava had previously received some tentative diagnoses in the past that were not retained, Donovan had doubts over whether the BPD diagnosis was actually accurate and thus did not place a great deal of significance on it.

Donovan several times spoke to his desire for psychoeducation in the early stages to help him work through the aforementioned barriers. He wished that someone was able to explain to their family "*what the condition is, what you can expect in terms of behaviourally and emotionally and so on. And possibly ways that you can assist, which is not to try and fix everything*." Donovan felt that for anyone with mental illness, their families are "*inextricably linked*" to their path to wellbeing, and thus "*it would be good if within the system, it then looks at certainly the nuclear [family]*" to ensure they feel supported and capable in their roles.

Thinking back, Donovan wished that he had assistance from someone in the MHS that would be able to educate and support the family throughout their journey. Without this, Donovan continually found himself "*doing things that turn[ed] out to be pretty misguided or not the way to handle it*" due to not having a proper understanding of what BPD was or how best to support Ava. I mentioned to Donovan that there are organisations in the community that do exactly this kind of work. However, Donovan wasn't aware that any of them existed.

Theme 4: Making Sense of BPD and Renarrating Fatherhood

This theme captures how the fathers reflected on their role and experiences in light of their child's BPD - re-examining the past, interpreting the present, and redefining what fatherhood means to them. Each father engaged in a unique sense-making process that shaped their identity as a parent. Leon grappled with what it means to be a father when there is no relational reciprocity in the father-son relationship, Simon reinterpreted his role as a father after years of limited closeness with his daughter gave way to newfound connection, while Donovan renarrated fatherhood by using reflective insights to guide his role, aligning support with his daughter's growth and autonomy.

Theme 4.1: Fatherhood in Name Only (Leon)

Leon discussed his ongoing struggles with making sense of what it actually meant for him to be a father to his son, given that Leon feels rejected by Andy and unwanted. Leon said that "*I don't think he really wants me as his father*" and that "*I feel like I'm just a father in birth, [...] that's all I have*." Despite his devotion, he lacked a meaningful relationship with his son: "*We don't have the relationship. And it's not for me wanting. It's really hard to have a relationship with someone that becomes abusive and that uses. It's not reciprocal*."

As mentioned earlier, Leon experienced rejection from his son from a young age. This feeling only compounded with time and became greatly exacerbated once his son became unwell. After Andy being diagnosed with BPD and being acutely unwell, Leon tended to only receive contact from Andy when he wanted something from Leon and this contact was typically accompanied by abusive behaviour:

> *He wanted to make me his receptionist. [...] To do everything for him, to sort out all his issues, to contact his lawyer, to contact, you know, his mother, his aunties, everybody, his landlord, the gym memberships, to deal with it all. And if I didn't, I was effing useless.*

After Leon decided that he needed to move "*five hours away from my son*" to "*force [physical distance] upon the relationship*" and protect his "*own health and wellbeing*", Andy "*hasn't talked to [Leon] of his own free will for months now*". Leon attributed this to his son knowing that Leon was no longer able to "*rescue*" him due to the geographical distance between them, but also to Andy rekindling his relationship with his mother and thus not needing Leon anymore. Leon described the "*hurt*" he felt "*as a dad*" about being "*sidelined again*", saying that "*you think I'd be happy*" with no longer being actively abused by his son, but ultimately, he "*just want[s] a normal relationship*".

Leon found himself grappling with what it meant to be a father under these circumstances: "*And so how do I as a father deal with what's happening for my son is so hard. Because I don't know what to do. [...] Is it okay to just never talk to him again*?" He struggled to reconcile his love and commitment with the absence of connection, while maintaining hope that the relationship may improve in the future:

> *Leon: It was my love for him that held me in there. It's just hoping one day our relationship would somehow waken up.*
>
> *Interviewer: Do you feel that that ever may happen?*
>
> *Leon: Yeah, he said I love you once. He sent happy birthday, just words, happy birthday via text this year. I don't know. I honestly don't know. You kind of hope. I don't understand his mind. I don't understand his world.*

Leon thus found himself trapped in a state of emotional purgatory. He knew that he needed boundaries to protect himself, yet could not shake his emotional devotion to his son. Leon was thus unable to move into a process of paternal role re-framing like the other fathers.

Theme 4.2: Reconstructing Fatherhood through Connection (Simon)

Simon discussed his changing perception of himself as a father over time, and how his newfound connection with his daughter bolstered his sense of efficacy and purpose. Simon recalled feeling like "*a hopeless dad*" both during and after the divorce from his ex-wife. Simon deeply wanted to spend quality time with Kathy, but was unable to, and thus didn't know where he fit in as a father. Simon felt the "*father-daughter relationship was, well, pretty vague, really. [...] Because we didn't have that time, [...] that everyday stuff.*"

This was a time before cellphones. Thus, if Simon was not physically with Kathy, they were seldom able to communicate, other than the occasional phone call to his ex-wife’s landline to speak to his daughter. Given the animosity present between Simon and his ex-wife, these calls did not happen particularly often. He felt this greatly diminished his worth and sense of efficacy and purpose as a father.

Given that their relationship was not particularly close, Simon only saw occasional glimpses of Kathy’s condition. His ex-wife gave Simon no indication that anything was wrong:

> *Simon: But their mother had things pretty well sewn up, yeah, in that respect, yeah. As in controlling the family situation.*
>
> *Interviewer: Yeah, I see. It's hard to feel like you have any power to change anything if you don't actually know what's going on.*
>
> *Simon: That’s dead right. Absolutely.*

Additionally, Kathy was too worried about upsetting him to tell him that she was experiencing mental distress:

> *But it's only recently that Kathy has really come out and really talked to me about this stuff, you know. And told me how she didn't want to, I don't know, upset me, let me know or whatever. [...] I said, well, thank God you have, you know. I mean, it is a little bit later on in life, but at least I'm getting some information.*

Simon thus felt left in the dark, disconnected from Kathy, and powerless to improve his relationship with her. However, after Kathy did eventually disclose her condition to Simon, he began to engage in some reflection on the past. The diagnosis provided some insight into interactions with Kathy that previously puzzled him, but now were able to be explained as symptoms of BPD: “*you actually think in your head, oh, that's what was happening. That's what* *was going- that's why*." This was validating for Simon as it provided a coherent narrative to what were previously just "*separate obstacles*" that he struggled to make sense of as his "*understanding of everything was really vague*".

Most significantly, Simon now felt empowered as a father and able to support Kathy. Simon noted the change in the quality of his relationship with Kathy after her disclosing her diagnosis as being "*very good, actually, and improving*" as they "*are communicating really good*". He felt that while he cannot get back those early years and he was not able to support her with her struggles when she was younger, he now has the opportunity to build the relationship he always wanted with her.

> *Interviewer: Has this experience changed the kind of father or dad that you feel like you are?*
>
> *Simon: Oh, shit, yeah. I'm not feeling incapable. Like, okay, the horse has already bolted, but I can still have a good relationship with my daughter. [...] I think that she would feel the same or say the same that our relationship is really good at the moment, especially after her sort of coming out and [...] talking to me.*

Theme 4.3: A Different Approach (Donovan)

Donovan's approach to how to be the best father he can to his daughter has been strongly shaped by his experience supporting her and his revisiting of the past in light of Ava's BPD diagnosis. The diagnosis offered a way of reinterpreting earlier experiences, providing some sense to a long series of challenges that lacked a coherent explanation. He recalled moments when his daughter was distressed at school and realised that he had not fully understood what she was going through at the time. Looking back, these reflections were often coloured by guilt, as he questioned whether he might have acted differently or recognised sooner what she needed.

Ultimately, these experiences and Donovan's developing understanding of Ava's condition have resulted in a shifting perception of his role as a father.

Donovan has largely always carried the same fundamental perspective to fatherhood - "*All we want is a daughter that has good self-worth and happiness amidst all the other things that occurs*" - however the means through which he's operated have changed. Thus Donovan's perspective on his own role as a father has shifted over the years as a result of his experience. Donovan was previously focused on fixing Ava's problems and being a protector to her, thus occupying a role centered on "*fix-it-ness [and] protectiveness*". If he felt he was unable to personally fix Ava's problems or protect her, a gulf in Donovan's conception of how he could support his daughter emerged. Donovan essentially wanted to be all the way in, trying to fix Ava's problems, or found himself taking a more hands-off approach, placing faith in Ava's care team and hoping that with their support "*that she'd come right*".

Over time, through conversations with Ava and other family members, Donovan learned that there was a middle ground between the aforementioned two approaches - one more based in communication, validation and active-listening-based support. Donovan's focus shifted to empowering her and supporting her to establish the emotional foundation to feel good and then be able to fix her own problems. Donovan related this idea to a quote from Wayne Smith, former coach of the Black Ferns, noting that:

> *He made a comment that resonated with me very much, in that he said that, for the men, the men have got to play well to feel good. [While the women] had to feel good to play well. [...] The emotional package [...] is so important. And the focus needs to be on there to be able to move on and move positively.*

Donovan found he needed to be less focused on "*if we do this or that and this happens, then we're going to be better*" and more focused on "*hav[ing Ava's] feelings and [...] issues validated, listened to*". Doing so allowed him to more effectively "*provid[e] an environment and support so [Ava] can feel well enough to make the changes [herself]*". Donovan sums this perspective shift up below:

> *She can't improve, she can't do well unless she's got the confidence and the wherewithal to be able to do it. To try and do things for [her] will be very short term in terms of any outcome, in terms of improvement.*

Given this perspective shift, as well as the knowledge of Ava's BPD diagnosis, Donovan reflected on past situations wondering what could have been different if he was able to operate from this perspective at the time. Donovan recalled the "*hell of a shock*" he got when phoned by a woman that Ava was boarding with during high school, who alerted him that Ava was self-harming. Donovan described this as "*one hell of a bolt out of the blue*" as "*there was not a lot of other factors or aspects that I'd picked up that [...] she was that level of degree really struggling*". Donovan was shocked to find out Ava was self-harming and struggling to this extent. He did not see it coming. Donovan found himself reflecting back, thinking that "*if we could go back over it, we'd be able to pick up a few things like that*".

This sense of guilt and the tendency to wish different approaches were taken in the past appeared several times in our discussion. One of the most significant instances of this was regarding an incident when Ava was struggling at high school. Due to "*a concern as a result of Ava not doing well at school*", a psychologist was "*a bit concerned that maybe there was something going on that shouldn't have been between Ava and myself*". This resulted in several investigative discussions between the psychologist, Donovan, and other members of the family, including Ava, independently.

While Donovan said that "*it was over reasonably quickly in terms of the potential allegation or concern [as] there was certainly nothing there*", he found the experience "*confronting*" and "*wasn't happy with the [psychologist]*". His reaction to the experience at the time was largely focused around his emotions towards the psychologist as it was a deeply upsetting experience. Looking back though, he found himself wondering if:

> *I perhaps didn't put the time and effort into, okay, how the hell has it got to this stage? [...] How did it get to this point when there was absolutely nothing to it? [...] Perhaps not enough attention on- back then into Ava, saying, hey, this girl's really struggling, which she was.*

Despite these reflections, Donovan expressed a strong sense of pride in his family and believed that they all did their best from the outset. Although the journey was long and challenging, he considered the current circumstances - both in relation to Ava's wellbeing and the family's relationships - to be positive. Consequently, Donovan felt content with how the events had ultimately unfolded. While noting that guilt and self-reflection are natural responses, he acknowledged his own evolution and growth in his support role as Ava's father, and believed that the family's efforts yielded the best possible outcome: "*I don't think there's a lot we could have done for a more positive outcome, in terms of Ava being in a position to have a good life*."

Chapter 5 Discussion and Conclusion

Synthesis of Key Findings

The study's four superordinate themes depict a journey of fathers navigating the emotional, relational, and identity challenges of supporting a child with BPD. Love and commitment remained steadfast in these fathers, even as traditional notions of paternal control and protection were repeatedly undermined by the complexity of the disorder, producing feelings of powerlessness in all the fathers. Coping emerged as a process of learning to balance persistence with self-preservation, and acceptance of the limits of their control with continued hope. For some, this process led to redefined and strengthened relationships, while for others it exposed enduring disconnection and loss.

The findings demonstrate that fatherhood in the context of BPD is often marked by emotional strain and disrupted identity, which can be particularly exaggerated for divorced fathers. Across participants, fatherhood emerged as a dynamic and evolving identity rather than a fixed role.

Powerlessness and the Limits of Fatherhood

All participants initially experienced powerlessness. However, this eventually subsided for Simon and Donovan as their relationships and understanding evolved, while it remained pervasive and consuming for Leon.

Leon had the most profound experience of powerlessness and limited agency of the participants. Consistent with prior literature, Leon's experience of cyclical crises with his son led to high levels of emotional exhaustion (Steele et al., 2019; Tariq & Mishra, 2025) and negative psychological symptoms, such as anxiety, depression and helplessness (Bailey & Grenyer, 2014). Leon had also begun to perceive his son's situation as chronic and immutable, much like the parents in Svensson et al.’s (2013) study, given that repeated hospitalisations and engagements with mental health professionals had not resulted in improvements to his son’s condition. Leon was thus trapped within powerlessness; he felt that nothing could be done, yet could not find acceptance.

Leon was the only father in this study that had any degree of direct engagement with the MHS. His experiences with the MHS precisely mirrored prior literature; fathers’ evaluations of the MHS appear contingent on the degree to which they feel valued and involved in communications with staff (Sharma, 2018; Wiens & Daniluk, 2009), however these instances are reported as very rare (McCormack & McCann, 2015; Piuva & Brodin, 2020; Svensson et al., 2013). Leon reported having one single good experience with the MHS, involving a phone call from a psychologist who helped Leon to feel understood and involved. However, this was the only time Leon said he ever had this experience.

Every other interaction Leon had with the MHS reflected the general consensus of the literature, which is that fathers frequently report feeling stigmatised, unvalued, shut out from communication and thus uninvolved in care and discharge planning (Johansson et al., 2012; Nyström & Svensson, 2004; Sharma, 2018; Wiens & Daniluk, 2009).

This exclusion leaves parents not only uninformed but also invalidated in their role as carers, which can exacerbate feelings of failure and isolation (Johansson et al., 2012; Nyström & Svensson, 2004). As Greally et al. (2024) note, the MHS itself can become a secondary stressor when support is inadequate or obstructive - a dynamic mirrored in Leon’s experience of feeling shut out of his son’s care.

Leon felt that he could not personally have any influence over his son’s condition, both inside and outside of the MHS. Additionally, he did not feel that the MHS were able to do anything to improve his son's condition due to its complexity and intensity. Thus in Leon's eyes, his son's condition was not improving and nor was Leon's relationship with his son, causing the hopelessness Leon experienced to remain pervasive and consuming, consistent with the experience of parents in Buteau et al.'s study (2008).

For Simon and Donovan, the powerlessness was only initial and was related to their inability to have agency or control over their situation. Over time, as their communication and relationship with their children improved, these experiences of powerlessness subsided. Both fathers initially struggled with their inability to personally fix their daughters' struggles. Simon initially felt hopeless and inadequate, uncertain of how to connect with his daughter or help her manage her distress. For Donovan, early on, he equated fatherhood with protection and problem-solving. When those strategies proved ineffective, he experienced guilt and frustration. This aligns with prior research showing that fathers often struggle with the limits of their ability to control their child's condition or shield their children from harm (Johansson et al., 2012; Sharma, 2018; Wiens & Daniluk, 2009).

Over time, however, Simon and Donovan came to accept that they could not directly resolve their daughters' difficulties. Instead, they redefined their role as one of support and empowerment, helping their daughters cultivate independence and self-efficacy rather than desiring to rescue them from distress. This shift reflects a positive adaptation consistent with Elliott's (2016) concept of caring masculinities, which emphasises relational attunement and emotional support over control.

This adaptation is not only beneficial for their children with BPD due to the development of fathers' sensitivity and attentiveness to emotional cues (Coltrane, 1996; Elliot, 2016), but also beneficial for fathers themselves, as this form of masculinity promotes fathers' emotional intimacy, self-esteem, respect and competence (Elliot, 2016; Hanlon, 2012).

Across all three accounts, feelings of hopelessness were closely linked to challenges in masculine and paternal identity. As O'Neil's (1981) theory of gender role conflict suggests, men experience psychological tension when traditional masculine norms such as self-reliance, control and stoicism conflict with their personal needs, values, or circumstances. In paternal contexts, this extends to fathers not living up to expectations in their role as a protector (Wojnicka, 2021). Each father, in his own way, grappled with not being able to meet internalised expectations of protection and control.

These findings demonstrate that powerlessness among fathers of children with BPD is multifaceted and temporal. These findings are congruent with the existing literature on hopelessness and limited agency in fathers of children with mental illness, but extend upon the literature by highlighting how such experiences are shaped by gender and evolve over time. Additionally, to my knowledge, this study is the first to identify decreased hopelessness associated with improved communication between a parent and a child with BPD over time.

Commitment and Connection (or Lack Thereof)

While all fathers in this study remained deeply committed to their children, the form that commitment took varied. Simon and Donovan were wholly invested in their role of supporting their daughters while Leon's experience was more complicated. Leon remained emotionally invested in his son, perpetually yearning for an opportunity for their relationship to improve. However, after enduring years of abuse in his attempts to support his son, Leon recognised he had to rescind his practical support, not only due to feeling it was futile, but also due to the toll it had taken on his wellbeing.

As in prior research, caring for a child with severe mental illness was described not as a choice but as an inescapable responsibility. Parents often portray their role as carers as unavoidable, remaining devoted despite feelings of entrapment or exhaustion (Greally et al., 2024). Consistent with previous findings, Simon and Donovan framed caregiving as an extension of their fundamental duty as a parent rather than a deviation from it (Fraser & Warr, 2009; Sharma, 2018). Leon had until only recently embodied this perspective. At the time of the interviews he was grappling emotionally with the decision to create distance from his care role, given that for so long he experienced this sense of fundamental duty to his son, regardless of the cost.

Leon's account revealed that commitment can coexist with disconnection. His son's ongoing behavioural and emotional volatility created a relational dynamic of chronic instability, forcing Leon into a state of constant hypervigilance. This experience is well documented among parents of individuals with BPD, who frequently describe walking on 'eggshells' or 'tip-toes' to avoid triggering their child's distress (Ekdahl et al., 2011; Kay et al., 2018; Mason & Kreger, 1998). To endure the hostility from his son while attempting to preserve empathy, Leon occasionally externalised his son's behaviour, mentally separating 'the illness' from 'the person', similar to the strategies employed by parents of children with anorexia nervosa described by Bellingham (2012).

For Leon, this dynamic compounded his disappointment that his relationship with his son bore little resemblance to his expectations of a father-son bond, echoing Sharma's (2018) finding that fathers of children with psychosis grieved the loss of an imagined relationship with their child. Knudson and Coyle (2002) reported that parents who reach acceptance regarding the limits of their parent-child relationship experience reduced emotional burden, but Leon had not achieved this transition. Leon struggled to shake his desire for connection with his son, and thus his commitment persisted without the accompanying peace that acceptance can bring, leaving him burdened by ongoing grief.

In contrast, Simon and Donovan's accounts demonstrate that being the father of a child with BPD is not inherently associated with maladaptation. Both men initially described immense challenges in their relationships with their daughters, yet over time their relationships became stronger than ever before. This is, to my knowledge, an outcome thus far undocumented in either the BPD caregiving literature, or the fathers of children with mental illness literature. Although some studies on other mental illnesses have reported improved family functioning over time (McCormack & McCann, 2015; Piuva & Brodin, 2020; Schön et al., 2009), this pattern has not previously been observed among parents of individuals with BPD, who are typically portrayed as locked in cycles of conflict and despair, with their child's condition being perceived as immutable.

For Simon and Donovan, the key turning point was communication. Simon's daughter's disclosure of her diagnosis opened a pathway for mutual honesty and understanding, enabling the two to strengthen their relationship. Donovan's family, meanwhile, cultivated open dialogue and reflective problem-solving within a cohesive household system. Walsh's (2016) Family Resilience Framework emphasises shared meaning making, open dialogue and connectedness as central to adaptation. Within Walsh's framework, several of the key processes in family resilience can be found in Simon and Donovan's relationships with their daughters, such as open emotional sharing (particularly for Simon), connectedness and collaborative problem solving.

Donovan's experience further underscores the protective function of family unity. His wife was his primary confidant and collaborator, consistent with prior research finding that spouses often represent the most significant source of support for parents of children with mental illness and that this buffers against caregiver strain (Boyd, 2002; Ekas et al., 2010). Their shared approach resembled West and Honey's (2016) 'co-pilot' model of collaborative parenting, whereby both partners jointly navigate the challenges of caregiving and typically achieve favourable outcomes. Donovan having such a strong, united, mutually-supportive family, all committed to supporting both each other and Donovan's daughter provided him with more resources to draw on, allowing for his relationship with his daughter to strengthen throughout their journey together.

Coping with the Ongoing Burden

This theme explores how fathers navigated the enduring psychological and practical demands of parenting a child with BPD. While all participants sought ways to cope, their strategies and outcomes diverged markedly over time.

In contrast to previous literature on the coping strategies of fathers of children with mental illness, the fathers in this study did not engage in information seeking in the early stages of their journey as a means of coping with the burden of their child's condition (Fraser & Warr, 2009; Howard, 1998; Wiens & Daniluk, 2009). Leon was largely resistant to this idea, believing it futile, while Simon and Donovan simply did not know where to obtain reliable information. Consistent with prior literature though, in the early stages of their journey, all fathers engaged in problem-focused coping strategies (or at least wished to, in Simon's case) as a means of trying to improve their child's condition and regain a sense of control over their situation (eg. Fraser & Warr, 2009; Howard, 1998; Johansson et al., 2012; Nyström & Svensson, 2004; Wiens & Daniluk, 2009; Wintersteen & Rasmussen, 1997).

For Leon, efforts to gain control were repeatedly thwarted. He advocated persistently for his son's treatment, attempting to secure a place in a DBT program, yet these efforts were undermined by systemic barriers and his son's behavioural volatility. When professionals excluded him from decisions or discharged his son for aggressive behaviour, Leon's sense of agency collapsed. Problem-focused strategies proved futile; Leon himself could not do anything, and the system he placed faith in to help his son could not do anything either. Unable to change his son's trajectory, Leon ultimately withdrew to protect himself, quitting his job and moving to a rural area. This retreat can be understood through Bowen's (1993) concept of emotional cutoff, wherein individuals distance themselves from the family system to manage stress. Although such separation may provide temporary relief, it often results in long-term guilt and relational strain, both of which Leon reported experiencing.

Simon's initial desire was to engage in problem-focused coping strategies - i.e. wanting to fix his daughter's problems - however, he had no idea how to do so and thus struggled with anxiety and feelings of inadequacy. Simon initially attempted to manage his anxiety through distraction, immersing himself in hobbies and activities. This aligns with findings that fathers often use private, task-based coping as a way to contain emotion and maintain a facade of composure (Howard, 1998; Nyström & Svensson, 2004; Wintersteen & Rasmussen, 1997).

However, unlike most fathers in these studies and in the male caregiver literature (eg. Haraguchi, 2023; Spendelow et al., 2017), Simon wasn't engaging in these coping strategies to gather information as a means of regaining control and a better outward perception of competency. He just felt helpless and powerless, and thus engaged in these strategies as a means to manage his anxiety. His coping may have appeared effective outwardly, yet internally it required constant effort to suppress anxiety and grief, consistent with Cook's (1988) argument that men’s grief often manifests through emotional management rather than visible distress. Simon’s adaptation began when communication with his daughter improved. Honest, vulnerable conversations replaced distraction-based coping strategies. He no longer perceived himself as failing to fix her problems but as successfully supporting her growth.

Donovan too initially engaged in problem-focused coping strategies, wholly occupied with trying to fix his daughter’s problems to no avail. Donovan’s family, particularly his wife, were an immense resource of support to him. Over time, they discussed and workshopped their approach to supporting their daughter, but this was a protracted process of trial and error. Eventually, Donovan realised that he could not fix his daughter’s problems, but this was a slow and gradual process, involving many discussions before moving to a place of acceptance. Donovan’s transition is consistent with Knudson and Coyle’s (2002) finding that reaching acceptance after repeated failed problem-focused attempts was a major contributor to reducing caregiver burden, though it was often a slow and painful process.

Donovan felt that if somebody could have explained the nuances of BPD to his family and helped them understand how to most effectively support his daughter, then he could have avoided the painful process described above. Donovan likely would have benefited from a psychoeducation course such as Family Connections, which has been found to significantly reduce burden and grief in several studies (Hoffman et al., 2005; Joyce et al., 2024; Krawitz et al., 2016). Particularly relevant for Donovan is that Hoffman et al.’s (2005) sample also reported a significant increase in mastery (i.e. an internal sense of competence and control) which was maintained at 6-month’s follow up. Donovan was unaware that such a program existed and was also unaware that several support services offered one-on-one skills-based support to family members of people with mental illness.

Donovan eventually moved into a place of acceptance, however he initially struggled with his inability to affect change. Despite lacking in a resource he strongly desired (psychoeducation and support to his family), he was able to draw on the strength of his family unit. Like Simon, Donovan underwent a shift in perspective, no longer seeing himself as a fixer or protector, but as an empowerer to his daughter.

No fathers in this study ‘kicked into gear’ and engaged in research and information seeking, contrary to what is typically seen in the literature (Huang et al., 2008). For Leon, this was largely due to diagnosis fatigue, whereby he did not initially place much faith in his son’s BPD diagnosis due to the MHS’ history of rescinding his previous diagnoses; Donovan felt that it was too complex of an exercise and did not know where to get quality information from; while Simon lived rurally and did not have internet access (his recruitment and interview procedure was conducted with the assistance of a friend).

However, consistent with previous literature (Knudson & Coyle, 2002), all fathers initially began with either desire to, or actual engagement in, problem-focused coping strategies. Eventually, all fathers ceased with their pursuit of problem-focused coping strategies and moved towards emotion-focused coping strategies, however only two of the fathers found acceptance with their situation and the limits of their control. Parents have described transitioning to a place of acceptance as being one of the most significant contributors to alleviating some of the emotional burden of caregiving (Knudson & Coyle, 2002). This is reflected in the differences in emotional wellbeing between Simon and Donovan - the two fathers who had found acceptance - and Leon, who had not and thus continued to struggle.

The two fathers that found acceptance and achieved adaptive outcomes were those whose children’s quality of life had the greatest perceived improvement, consistent with Addington et al.’s (2003) finding that caregivers’ emotional well-being was associated with their understanding and evaluation of their care recipients’ illness. Leon’s continued struggle with acceptance and hopelessness aligns with the experiences of fathers of children with mental illness who reached adulthood but struggled to achieve independence in Fraser and Warr’s (2009) study.

None of the fathers in this study engaged with support groups, which is congruent with the low uptake rates seen in the literature (Fraser & Warr, 2009; Sharma, 2018) and the trend for help-seeking rates to be low among males for psychological difficulties (Yousaf et al., 2015). Only Leon was aware of relevant family support organisations and support groups, however this was due to his ex-wife sharing this information rather than Leon himself searching for these services.

No fathers reported successful utilisation of social support. Leon and Simon tried to engage with others, but felt that no one wanted to hear about their issues. This experience is commonly reported in the literature, with parents in Knudson and Coyle’s (2002) study finding themselves socially isolated due to their roles; the fathers in Pfeiffer’s (2001) study withdrawing socially due to believing that no one wanted to hear about their situations or emotional burdens; and the fathers in Sharma’s (2018) study believing that their social contacts simply would not understand. Donovan and his wife did occasionally speak with a particular pair of family friends about their situation, however not often or in much detail. This is somewhat in keeping with a pattern seen in previous studies whereby most fathers cite only one to two people other than their wife that they relied on for support (Pfeiffer, 2001; Wintersteen & Rasmussen, 1997).

It is important to note that while the fathers in this study may appear to seemingly have engaged in several of the hegemonic masculinity ‘scripts’ (such as the ‘strong and silent’, ‘tough guy' or 'independent' scripts) which Mahalik et al. (2003a) described as barriers to help-seeking, the reality is more complex. Simon's attempts to regain control over his emotions appeared to be a coping mechanism rather than a means of demonstrating elements of hegemonic masculinity (such as stoicism and suppression of emotions) to others. Simon's coping was instrumental rather than performative as he was unaware of organisation-based support and did not feel like his social contacts wanted to listen; it was simply a means of surviving. Once Simon was able to reconnect with his daughter, he reported his vulnerable conversations with her as being key to his improved wellbeing. Leon also described being very open about his experience to others, but that this tended to drive people away; he tried time and again to get support from others to no avail. Donovan also wished that he had help in the form of psychoeducation courses or a family support worker.

The reason that these fathers did not engage with social or organisation-based support was not due to a desire to appear stoic, independent and strong. In reality, these fathers wanted help - they just did not know how or where to get it, and felt that no one wanted to listen to their experiences.

Making Sense of BPD and Renarrating Fatherhood

This theme captures how the participants made sense of their experiences and redefined what it meant to be a father in the context of their child's condition. The fathers' ability to adaptively re-frame their paternal role appeared contingent on the quality of their relationship with their child. Their child's diagnosis also appeared to provide a framework for interpreting years of distress, conflict, and self-doubt.

Leon initially described his son's diagnosis as being insignificant, but after reading *Stop Walking on Eggshells* (Mason & Kreger, 1998), he found the diagnosis incredibly validating and felt it offered a coherent framework to both his and his son's experiences. Both Simon and Donovan reported that with time and reflection, their child's diagnosis assisted in making sense of previously difficult to understand past events and behaviours in their relationship with their child. In Donovan's case, the diagnosis made him reflect with some guilt for not noticing signs of the condition earlier on, or not reacting in ways he later wished he did, consistent with the experiences of fathers in previous studies (Wiens & Daniluk, 2009; Wintersteen & Rasmussen, 1997).

Grealy et al.'s (2024) systematic review of the parents literature highlights the mixed experiences of families after receiving a diagnosis - for some it brings relief and clarity, while for others it is devastating. For Simon, this was initially devastating as he did not understand BPD or know what to do with this information. He had no one to help guide him through it or make sense of the diagnosis and thus struggled with feelings of helplessness and inadequacy as a father.

For Leon, initially he did not place significance on his son's diagnosis, largely due to diagnosis fatigue. He and his son had been through a long and disappointing process journeying through the MHS, filled with a history of tentative diagnoses that ended up being rescinded. This is captured in Perkins et al.'s (2018) systematic review of service user, clinician, and carer perspectives on diagnosis, which found that misdiagnosis caused distress and a loss of confidence in services. Leon also reported a continued struggle with making sense of his son's condition, consistent with fathers in Sharma's (2018) study who experienced a pervasive lack of meaning making with regard to their child's psychosis; they could not understand why their child had become ill and they struggled to understand their own experience of supporting their child, despite significant efforts.

For Donovan, his daughter's diagnosis did aid reflection and meaning making, however it primarily brought him benefit due to the positive impact it had on his daughter. Donovan described his daughter's diagnosis as incredibly validating for her, and thus a positive for himself. Donovan's daughter's experience is consistent with some service users' perspectives on receiving diagnosis who report that it can offer a framework to understand their experiences, provide a sense of control, optimism for the future, relief and validation (Hayne, 2003; Loughland et al., 2015; Perkins et al., 2018; Pitt et al., 2009; Rose & Thornicroft, 2010). Additionally, amongst individuals diagnosed with BPD, receival of diagnosis has been reported to provide focus and a sense of control, as well as optimism for recovery (Horn et al., 2007). Donovan's experience shows the impact that accurate diagnosis for service users can have on parents and carers; consistent with Bowen's (1993) family systems theory, a child's experience with the MHS will impact their parents also.

Two of the fathers experienced a reframing of their perceptions of their role as fathers, while Leon appeared in a transitional phase, questioning what it meant to be a father in his position, but lacking the answers. As discussed earlier, these fathers placed great emphasis on their perceived paternal roles as protectors of their children. After accepting their inability to protect their children from BPD or fix their problems, they found themselves undergoing a renegotiation of what it means to be a father.

For Leon, given his experience of rejection by his son, he continued to struggle with what it meant to be the father of a child he felt did not want him in his life. Leon's experience appears to be a novel one within the literature - fathers of children with mental illness typically describe their children as being dependent on them, rather than driving them away. In my research I was unable to find information on the experiences of parents whose mentally-ill children had rejected their support.

For Simon and Donovan, they shifted their perspectives on their roles as fathers to one of a supporter or empowerer rather than a protector. The manifestation of this shift largely took place through a larger emphasis on effective communication (particularly validation and active listening) rather than on solutions-focused interventions. Employing validation and active listening underpins much of the skills-based content in BPD psychoeducation courses and is effective due to its ability to reduce distress for both parties in communication and to improve their relationship (Hoffman et al., 2005; Taurogiński, 2025).

Validation refers to communication which signifies the recognition of the subjective importance and meaningfulness of one's experiences (Taurogiński, 2025). It typically reduces emotional arousal in the recipient of the validation and enhances trust, thus providing a crucial skill for BPD-carers (Krawitz, 2012; Taurogiński, 2025). Validation is a key component of active listening, which Fruzzetti and Shenk (2008) describe as an approach to communication which aims to non-judgementally, and with full attention, listen to and understand what the individual with BPD is saying and experiencing descriptively. This can be done through acknowledging or reflecting back to the speaker one's understanding of what has been communicated, as well as asking clarifying questions which communicate curiosity, interest and a genuine willingness to accept and understand.

Two of the fathers in this study can be seen to have embodied the 'new father role identity' described by Dick (2011); one characterised by being more emotionally available to their children and nurturing. Within this conceptualisation, the father's role is to provide "necessary and important psychological sustenance that serves to solidify the child's sense of self and self-esteem" (Dick, 2011, p. 109). This conceptualisation of fatherhood is congruent with the 'caring' or 'new' masculinities that Elliot (2016) and Kaplan et al. (2017) respectively argue have emerged in recent times. Leon pined to embody the role identity described by Dick (2011), but was unable to do so due to his son's rejection, whereas Simon and Donovan over time, through communication with their children - and in Donovan's case, his wife and other daughter - effectively transitioned into this role identity to positive effect.

Implications

This study has considerable implications for clinicians and service providers. A select few implications will be discussed in detail in this section.

Whānau-Inclusive Practice

This study reinforces the urgent need for New Zealand's MHS to meaningfully integrate whānau into service users' care and recovery processes. Current legislative frameworks permit family involvement within appropriate ethical boundaries, however, consistent with international findings (eg. Knudson & Coyle, 2002; McCann et al., 2011), overly restrictive interpretations of confidentiality by clinicians often result in family members being excluded from much of their loved ones' care (Government Inquiry into Mental Health and Addiction [GIMHA], 2018). The *He Ara Oranga* report (GIMHA, 2018) concluded that although the legislative foundations adequately allow for the integration of whānau into service users' care and recovery processes while respecting service user autonomy, inconsistent guidance across agencies creates confusion and inhibits whānau-inclusive practice. Consolidating these various guidelines into a unified government-mandated document would provide clarity for clinicians and improve confidence and competence in engaging families.

Clinicians should establish discussions regarding whānau involvement at the very beginning of treatment, ensuring that service users' preferences and boundaries are explicitly documented and revisited throughout care. This early engagement helps balance respect for client autonomy with the recognition that whānau often serve as critical partners in recovery, and ensures that the role of whānau is routinely considered as standard procedure. However, clinicians should remain mindful of complex family dynamics, including the elevated rates of childhood trauma and abuse reported among individuals with BPD (Paris et al., 1994; Zanarini et al., 1997).

Implementing whānau-inclusive practice has demonstrated measurable benefits at both individual and service levels. Evidence indicates that for service users, whānau engagement enhances wellbeing, strengthens support systems, and reduces rates of readmission and missed appointments (Durbin et al., 2007; Hariman et al., 2020; Te Pou, 2022). For whānau, exclusion from their loved one's care by the MHS is associated with psychological distress (Seif et al., 2022), which was clearly identifiable in Leon's case as well as the literature discussed in the introduction.

Whānau-inclusive care is also culturally imperative. For Māori and Pasifika communities, wellbeing is inherently relational, grounded in the interconnectedness of whānau and aiga (GIMHA, 2018; Te Pou, 2022). Working with an individual in isolation from their whānau is inconsistent with the principles of whanaungatanga (kinship, sense of family connection) and culturally unsafe (GIMHA, 2018). Accordingly, services must deliver culturally-responsive, whānau-focused support that enhances both individual and collective wellbeing.

Recognising and Supporting Fathers as Equal Carers

A particularly salient implication of this research concerns the under-recognition of fathers within mental health services. Leon’s experiences highlighted a persistent bias toward mothers as the default point of contact, even when he was actively involved or listed as the primary caregiver. This tendency has also been identified amongst fathers accessing healthcare services for their children, noting that service providers tend to see fathers as “people who support mothers”, causing them to feel “left at the sideline” (Haraguchi, 2023, p. 7). Such practices marginalise fathers and reinforce gendered assumptions about caregiving. Services should therefore ensure that intake procedures explicitly identify and validate both parents, inquire about the family’s preferred point of contact, and engage fathers as equal partners in the care process.

This is particularly important for fathers like Leon and Simon who are separated from the mothers of their children, as if they are not intentionally considered by service providers, they often risk being forgotten altogether. For separated fathers, equitable access to information and participation in care planning is especially important. Systematic deferral to an ex-partner - as seen in Leon’s account - can undermine paternal efficacy and exacerbate feelings of exclusion. Practitioners must be aware of these risks and strive to establish transparent communication protocols that include all relevant caregivers while respecting the service user’s consent parameters.

At the organisational level, mental health services should adopt explicit father-inclusive policies and training initiatives. Research demonstrates that professional training in father engagement strategies increases practitioner confidence and competence, as well as rates of father participation (Humphries & Nolan, 2015; Scourfield et al., 2015). Father-inclusive organisational strategies might include flexible session scheduling for programs, inclusive language in service materials, and ongoing monitoring of father engagement rates (Lechowicz et al., 2019). Beyond improving service equity, such inclusion strengthens family systems and ultimately benefits the service user's recovery trajectory.

Divorced or Separated Fathers

The experiences of Leon and Simon in this study highlight the additional challenges that divorced or separated fathers of parents of children with BPD face. Divorce often disrupts family stability, limits fathers' day-to-day involvement, and can contribute to declines in parent-child relationship quality and paternal wellbeing (Amato, 2004; Shapiro & Lambert, 1999). These effects can be amplified when fathers perceive limited agency regarding their children's care, compounding stress and diminishing their sense of paternal efficacy (Violi et al., 2022).

Separated fathers thus not only experience the typical difficulties of other fathers of children with BPD, but lack the protective factor of family resources that fathers like Donovan have (Boyd, 2002; Ekas et al., 2010). They also may experience amplified powerlessness due to reduced contact with their child, less access to information and potential exclusion from the MHS due to their child's mother being perceived as the default carer. This places separated fathers of children with BPD at particular risk of distress, underscoring the need for services to adopt inclusive practices that, with service user consent, actively maintain paternal involvement despite changes in family structure, as well as refer these fathers to appropriate support services.

Psychoeducation and Validation-Based Communication Training

A central implication of this research is the critical role of communication in fostering family resilience. For Donovan, moving from a stance of problem-solving and protection to one of validation and empowerment resulted in reduced conflict and a strengthened relationship with his daughter. This shift echoes findings by Hoffman et al. (2005) and Fruzzetti and Shenk (2008), who argue that validating communication is among the most powerful relational tools available to families affected by BPD.

Traditional models of masculinity and fatherhood often socialise men to approach caregiving through protectionist, solutions-based action (Wojnicka, 2021). Yet for fathers of children with BPD, such approaches can unintentionally heighten distress, as they may be perceived as invalidating (Fruzzetti & Shenk, 2008). Donovan and Simon's journeys highlight how relinquishing the desire to fix and prioritising effective communication can restore connection and relational strength between father and child.

Support interventions should therefore extend beyond basic psychoeducation and towards training in validation-based and emotion-focused communication. Psychoeducation remains an imperative starting point for families supporting someone with mental illness and is associated with improved outcomes for both service user and family (Hoffman et al., 2005; Joyce et al., 2024; Krawitz et al., 2016; Rodolico et al., 2022). Beyond this though, fathers would likely benefit from evidence-based programs such as Family Connections (Hoffman et al., 2005) and DBT-informed family interventions which teach the aforementioned relational skills, equipping them to feel more confident in their abilities to appropriately support their children.

Policy and System-Level Reform

At the policy level, alignment is needed between existing frameworks that already advocate for whānau-inclusive care and the realities of frontline service delivery. Both the Ministry of Health's *Involving Families* guidelines (2000) and the Royal Australian and New Zealand College of Psychiatrists' *Partnering with Carers* statement (2020) emphasise the central role of whānau/family in recovery. Yet, a persistent gap remains between these ideals and clinical practice. Addressing this discrepancy will require targeted implementation strategies, workforce training, and accountability mechanisms to ensure family-inclusive practice is truly embedded.

The Ministry of Health's (2000) guidelines already identify key clinician responsibilities, such as recognising the role of family, facilitating access to information, and maintaining ongoing communication throughout treatment. Translating these principles into practice could involve mandatory family engagement checkpoints within care planning, as well as immediately following service user diagnosis engaging in discussions with whānau regarding ways to access relevant information, psychoeducation programs and support services.

Since 1 July 2024, all New Zealand mental health and addiction services have been mandated to report statistics on whānau engagement (MH&A KPI Programme, n.d.). This is a positive step in the right direction for the sector and aims to address the aforementioned issues through transparent reporting. However, the current reporting mandates just require reporting whether whānau engagement occurred (i.e. whether whānau were contacted or present at a meeting). Previous studies report parents' frustrations about being present in meetings but perceiving them as one-sided, feeling they were simply there to receive information on decisions already made, rather than to serve as active participants (Giffin, 2008).

Thus, further development to reporting should include a qualitative component wherein detail is provided around what the whānau engagement actually looked like, and if feasible, capture feedback from the whānau involved. Of participating services, between 2017-2021, whānau engagement from services averaged at 51% (Te Pou, 2022). All services must now report whānau engagement statistics, and the most up-to-date statistics list the average at 43%, an 8% decrease from the aforementioned figure (MH&A KPI Programme, n.d.). While KPI reporting is a welcomed initiative, it highlights that there remains much work to be done.

Limitations

This study’s findings should be understood within the context of several methodological limitations. The study was conducted using an IPA design, which prioritises depth of understanding over breadth of representation. While this idiographic approach enabled rich exploration of fathers’ lived experiences and meaning-making processes, it inherently limits the generalisability of findings. The intention of IPA is not to produce statistically generalisable results but to illuminate the experiences and processes of meaning making for a particular group of people. Thus, the experiences captured here reflect the perspectives of a small number of participants and cannot be assumed to represent all fathers of children with BPD.

Additionally, the sampling methods employed for this study may have reduced the likelihood for Māori and Pasifika participation. While services pertaining to these communities were contacted during recruitment, more culturally-sensitive efforts to engage these communities is likely required for future research. This could include relationship and partnership building efforts with community leaders and services serving these communities, the incorporation of indigenous knowledge models into the research methodology, and/or a Māori or Pasifika researcher contributing to the study (Glover et al., 2015; Ofe-Grant, 2023). The demographic composition of the sample also limits the scope of these findings. Participants were relatively homogenous in age and culture, all being Pākehā males in their late 50s or older. Thus while it was beyond the scope of the present study to have a representative sample, the experiences of fathers from non-Pākehā cultures unfortunately remain unexplored.

A further limitation concerns potential sampling bias arising from the recruitment pathways used. The study may have unintentionally captured fathers positioned at opposite ends of the adaptation spectrum. Leon, who self-referred, was still experiencing distress and relational strife. Simon and Donovan were invited to participate by their daughters, and had relationships now characterised by openness, communication, and relative stability. As a result, the sample reflects two contrasting points along the caregiving trajectory - one of ongoing struggle and one of adaptation and reconnection.

Fathers who were struggling may have reached out because participation offered a means of externalising their experience that was not available to them socially, while fathers with positive relationships with their children may have only engaged due to their children's request. Fathers occupying the middle ground - those who may be coping inconsistently, experiencing partial improvement, remaining uncertain about their role, or have ambivalent relationships with their children - were not represented. Future research could seek to capture a broader continuum of experiences by recruiting through multiple channels, including clinical services, support networks, and community outreach, to include fathers at varying stages of adjustment and relational repair.

Finally, the study's cross-sectional design captures participants' reflections at a single point in time. Fathers' narratives represent meaning making after years of experience, which may be shaped by hindsight and current relational contexts. Longitudinal qualitative or mixed-methods research would allow for more dynamic observation of the process of fathers' meaning making, including how paternal perceptions, coping, and identity evolve across their journeys.

Future Research Directions

Building on the present study, three directions for future research warrant exploration: expanding and diversifying father perspectives; undertaking longitudinal and process-focused work; and developing and evaluating father-specific interventions.

Larger and more diverse samples are needed to test the transferability of this study's findings. A broadened participant pool would help determine whether the patterns of early powerlessness, enduring commitment, shifts from problem-focused coping, and redefinition of fatherhood generalise across broader demographic variables. Of particular importance is the inclusion of Māori and Pasifika fathers, for whom caregiving and identity are embedded within collectivist frameworks, wherein these cultures tend to perceive the self as an inseparable part of the whānau collective (Podsiadlowski & Fox, 2011). Doing so would illuminate how cultural values and relational systems shape paternal coping and adaptation in the context of BPD. Additionally, targeted research on separated or divorced fathers could clarify how co-parenting arrangements and restricted involvement with services compound distress and impede meaning making. The two divorced fathers in this study experienced considerable isolation and had access to less resources than the married father.

The present study captured fathers' experiences at a single point in time. However, adaptation and meaning making are ongoing processes. Longitudinal research could trace trajectories from crisis and helplessness toward acceptance and relational repair. Further, the current findings suggest that shifts in communication may serve as mechanisms of adaptation. This resonates with prior work showing that validation-based communication reduces interpersonal conflict and enhances family functioning in BPD contexts (Fruzzetti & Shenk, 2008; Hoffman et al., 2005). Quantitative or mixed-methods research could test these mechanisms empirically, examining whether candidate mechanisms of change such as communication style predict improvements in paternal wellbeing, family cohesion, or relationship quality, thereby identifying mediators and moderators of adaptation.

Additionally, the findings of the present study - which note that powerlessness is not inherently enduring and that positive outcomes are possible - may be indicative of a sampling bias in previous studies. These studies may have only included parents actively struggling or not yet at a point of positive adaptation. A longitudinal, cohort-based study which follows parents from diagnosis would theoretically allow for these previously unrepresented parents' experiences to be highlighted in research.

Third, there is a clear need for intervention development and evaluation tailored to fathers. Existing family programs (e.g., Family Connections) offer empirically valuable skills, however the program principally attracts female family members (Boritz et al., 2021; Hoffman et al., 2007). This means that fathers are under-represented in these programs’ delivery and evaluation. Under-representation limits the evidence base regarding the effectiveness of these programs for fathers. Strategies to make the program more accessible to fathers may be required, or alternatively, designing a similar program tailored specifically for fathers which employs pre-, post- and follow-up-testing to provide empirical validation.

Together, these directions would deepen our understanding of the experiences of fathers of children with BPD, improve cultural and gender sensitivity in caregiving research, and provide an empirical foundation for targeted supports that empower fathers as active partners in recovery.

Conclusion

This study sought to illuminate the lived experiences of fathers of children with BPD, a perspective that has received little attention in the existing literature. Using an IPA approach, it explored how three fathers made sense of their roles, relationships, and identities in the context of complex relational challenges, coping, interaction (or lack thereof) with supports, and perspectives on fatherhood.

Through this analysis, four superordinate themes were identified that captured the fathers' experiences: Powerlessness and the Limits of Fatherhood; Commitment and Connection (or Lack Thereof); Coping with the Ongoing Burden; and Making Sense of BPD and Renarrating Fatherhood. These themes illustrated how these fathers navigated the ongoing tension between expectations of fatherhood and the emotional realities of caring for a child with a relationally demanding disorder.

Taken together, the findings portray these fathers' experiences as both profoundly challenging and, for some, deeply meaningful. Each participant's account illustrated the complexity of maintaining connection in relationships marked by volatility and uncertainty. Yet, the study also revealed that change is possible: effective communication and acceptance emerged as processes through which fathers could re-establish or strengthen connection and find renewed purpose in their roles.

This research offers an account of fathers of children with BPD as active and reflective, challenging assumptions that position them as peripheral carers. It also offers practical implications for clinicians and services seeking to engage fathers more meaningfully in family-inclusive care.

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Appendices

Appendix A: Participant Information Sheet

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

Participant Information Sheet

Study Title: The Experiences of Fathers of Children with Borderline Personality Disorder

Researcher: Riley Noonan

Supervisor: Associate Professor Dr. Richard Fletcher, PhD, School of Psychology

Institution: Massey University

Contact Information for the Researcher: [redacted]@massey.ac.nz

Contact Information for the Supervisor: R.B.Fletcher@massey.ac.nz

Who is doing this research?

My name is Riley Noonan and I am a Master of Science (Psychology) student in the School of Psychology at Massey University, New Zealand. My supervisor for this project is Associate Professor Dr. Richard Fletcher, PhD (School of Psychology, Massey University).

I am interested in the experiences of family members of people with mental illness, particularly fathers, for whom there has been very little research done on their experiences.

Introduction

You are invited to take part in a research study examining the experiences of fathers whose children have borderline personality disorder (BPD).

The aim of this study is to develop the understanding of what these fathers experience as there is currently no research on this topic. These experiences could include fathers’ changing perception of their role as a father, how their lives and relationships have been affected by their child becoming unwell and the ways in which they have coped with this change.

Doing so will lay the foundation for subsequent research in the field and provide valuable information to inform support initiatives aimed at fathers of children with BPD.

The data collected in this research will be used as part of a Master of Science (Psychology) thesis at Massey University.

If you would like to participate, please contact the researcher at [redacted]@massey.ac.nz

What Does Participation Involve?

If you agree to participate, you will be asked to take part in several interviews, which will be conducted either in person, via video call, or over the phone, depending on your preference. These interviews will last approximately an hour. The total number of interviews will likely be either two or three.

The interviews aim to capture rich accounts of fathers' experiences, and thus require more than a single hour. You are welcome to participate via one longer interview rather than multiple hour-long ones if you would like.

The interview(s) will focus on your personal experiences during your journey navigating your child's mental health challenges, the obstacles you have encountered and how you coped with and/or overcame these.

The interview will be audio-recorded to ensure accurate transcription and analysis. You may decline to answer any question, and you are free to pause or stop the interview at any point.

Why Have You Been Invited to Take Part?

You have been invited to take part due to meeting the study's inclusion criteria of:

- You are the father of a child diagnosed with borderline personality disorder
- Your child received a diagnosis at least two years ago

Your Rights and Confidentiality

- Participation is entirely voluntary, and you can withdraw at any time without needing to provide a reason. If you withdraw, any data collected up to that point can be removed if requested.
- Your responses will remain confidential. No identifying information will be included in any reports or publications. All information included in these will be de-identified and reported using pseudonyms.
- Non-anonymised data in the form of signed consent forms and audio recordings are collected and retained as part of the research process.
- Confidentiality will only be voided if the researcher has a strong belief that there is a serious risk of imminent harm or danger to either the participant or another individual, or if a serious crime has been committed.

Potential Risks and Benefits

- Sharing your experiences may contribute to a better understanding of fathers' roles and needs in similar situations. Your participation is thus beneficial to the future of research in the field and to organisations and services looking to provide support for fathers of children with mental illness.

- Some topics may be emotionally challenging. If at any time you feel uncomfortable, you may take a break or discontinue the interview. Information on relevant support services will be provided below.

Audio Recording and Use of Data

- With your consent, the interview will be audio-recorded for accuracy in transcription and analysis.
- You have the right to request a copy of your interview transcript and suggest corrections if necessary.
- Data will be securely stored on a password-protected cloud storage folder
- Any physically signed consent forms will be scanned digitally then physically destroyed. The scanned copies or digitally signed forms will be stored for 20 years as per Section 12.5 of the General Disposal Authority for New Zealand Universities and then digitally destroyed.
- The de-identified interview transcripts will be retained for one year after the conclusion of the study and then digitally destroyed.
- The researcher and supervisor are the sole parties with access to the stored data.

What Will Happen With the Results of the Study

- The data collected in this research will be used as part of a Master of Science (Psychology) thesis at Massey University.
- The thesis may be submitted for publication in an academic journal after submission to the University, and/or discussed with external parties such as at conferences or to support organisations.

Ethical Considerations

This research has undergone a peer review process and has been assessed as low risk. As a result, it has not been reviewed by Massey University's Human Ethics Committees. The researcher listed above is responsible for ensuring ethical research practices.

If you have any concerns about the ethical aspects of this research and would like to speak with someone other than the researcher, please contact Massey University Human Ethics by email: humanethics@massey.ac.nz.

Support Services

If you experience any distress as a result of participating in this study or would like support, the following services are available in New Zealand:

- Need to Talk? 1737 – Free call or text 1737 to speak with a trained counsellor, available 24/7.
- Lifeline – Call 0800 543 354 for free, confidential support from trained counsellors.
- Samaritans – Call 0800 726 666 for access to a 24/7 crisis line for those experiencing loneliness, depression, despair, distress or suicidal feelings

- Skylight Trust – Provides support for those experiencing grief, loss, or trauma. Visit www.skylight.org.nz or call 0800 299 100.
- Yellow Brick Road – Provides support and information for family members of individuals experiencing mental illness. Visit www.yellowbrickroad.org.nz or call 0800 732 825.
- Parent Help – A confidential helpline for parents needing support. Call 0800 568 856.

Further Information

If you have any questions or require further details about the study, please contact the researcher or supervisor using the contact information supplied at the beginning of this document. If you would like to receive a summary of the findings upon study completion, you may request this by emailing the researcher.

Thank you for considering participation in this study.

Appendix B: Consent Form

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

Consent Form

Study Title: The Experiences of Fathers of Children with Borderline Personality Disorder

Researcher: Riley Noonan

Supervisor: Associate Professor Dr. Richard Fletcher, PhD, School of Psychology

Institution: Massey University

Contact Information for the Researcher: [redacted]@massey.ac.nz

Contact Information for the Supervisor: R.B.Fletcher@massey.ac.nz

Consent Statement

- I confirm that I have read and understand the Participant Information Sheet for this study.
- I have had the opportunity to ask questions and have received satisfactory answers.
- I understand that all personal information will remain confidential
- I agree that data gathered in this study will be stored anonymously and securely.
- I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason.
- I agree to participate in this study under the conditions set out in the Participant Information Sheet

Participant Details

Full Name (Printed): ________________________________

Signature: ________________________________

Date: ________________________________

This form must be signed and returned to the researcher before participation in the study begins.

Appendix C: Recruitment Email/Post Template

Example Email Sent to NGOs and Mental Health Services

Kia ora. My name is Riley, I work supporting the families of people with mental illness and am currently completing my psychology masters degree where I'm writing a thesis on the experiences of fathers of children with borderline personality disorder.

The aim of this study is to develop the understanding of what these fathers experience as there is currently no research on this topic. These experiences could include fathers' changing perception of their role as a father, how their lives and relationships have been affected by their child becoming unwell and the ways in which they have coped with this change.

For the research, I am looking to interview several fathers to explore their experiences. There will likely be approximately 2-3 hours of interviews involved, with these likely being done in two separate interviews (unless participants would rather do a single long one). The interviews can be conducted in-person if based in Auckland, otherwise will be conducted via video call.

Their children can be of any age (including adult children). The only criteria for participation is that they must be father to a child who has received a diagnosis of BPD at least two years ago. Please see the attached Participant Information Sheet for any further information.

Any interested whānau can get in touch via email at [redacted]@massey.ac.nz or this email address, [redacted]@gmail.com

I would be endlessly grateful if you were able to share this within your networks, or with any whānau you have worked with that meet the participation criteria. I have attached the recruitment flyer in case you or any other parties were interested in advertising the research in any of your facilities. My sincere thanks for your consideration.

Ngā mihi,

Riley

Example of Facebook Post on BPD Support Group

Kia ora. I hope you're all doing well today and thank you for accepting me into this group - I think it's such a wonderful initiative. I'm interested in knowing if any of your fathers (or if you are yourself the father of someone with BPD) would be interested in sharing their/your experiences with me?

My name is Riley. I work supporting the families of people with mental illness, and I'm currently completing my psychology masters degree where I'm writing a thesis on the experiences of fathers of children with borderline personality disorder.

The aim of this study is to develop the understanding of what these fathers experience as there is currently no research on this topic. These experiences could include fathers' changing perception of their role as a father, how their lives and relationships have been affected by their child becoming unwell and the ways in which they have coped with this change.

For the research, I am looking to interview several fathers to explore their experiences. There will likely be approximately 2-3 hours of interviews involved, with these likely being done in two separate interviews (unless participants would rather do a single long one). The interviews can be conducted in-person if based in Auckland, otherwise will be conducted via video call.

Their children can be of any age (including adult children). The only criteria for participation is that they must be father to a child who has received a diagnosis of BPD at least two years ago. Please scan the QR code on the flyer below to access the Participant Information Sheet for any further information. Any interested whānau can get in touch via email at [redacted]@massey.ac.nz or [redacted]@gmail.com.

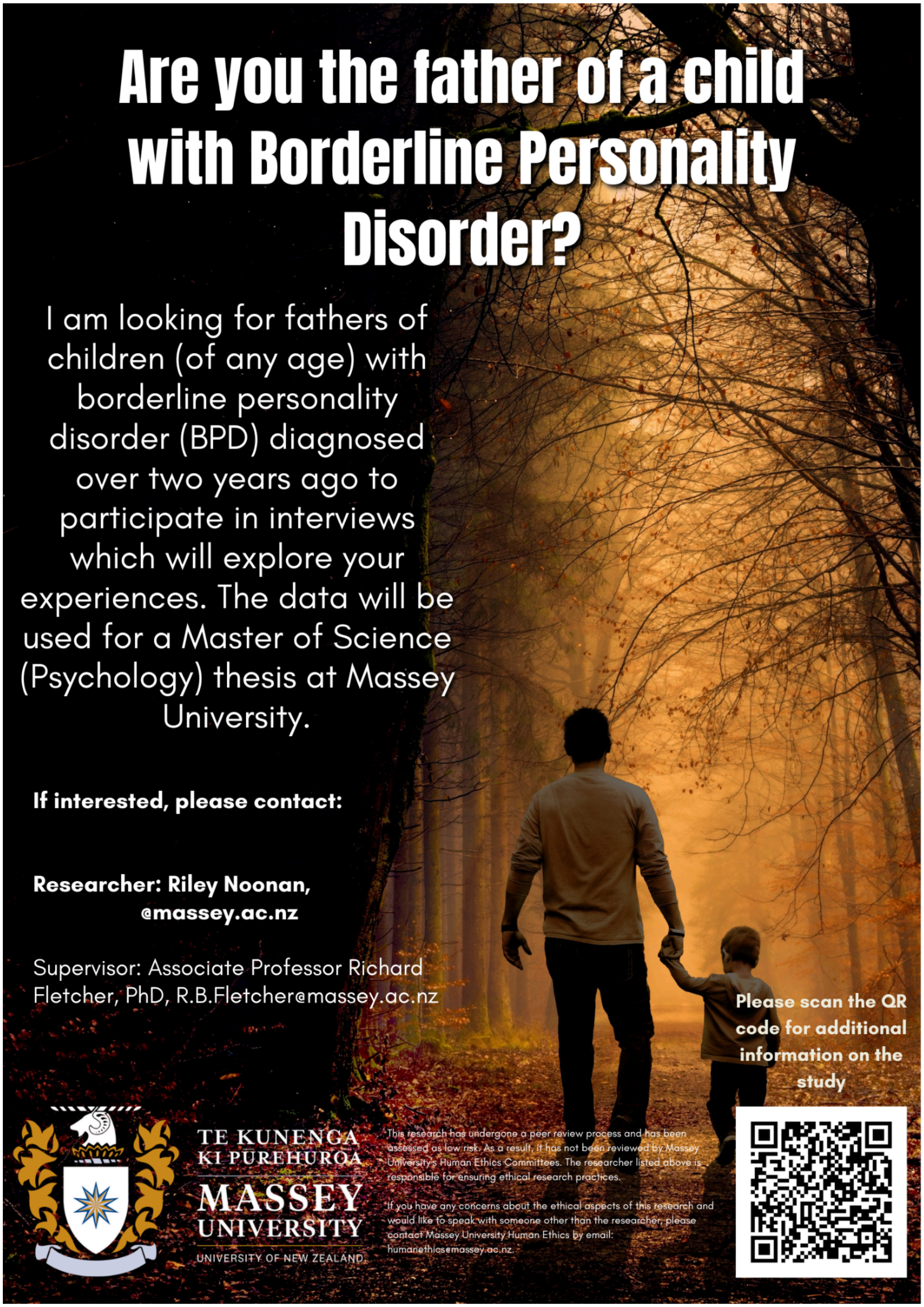
If you meet the criteria, I would be endlessly grateful if you were willing to take part and share your experience with me. If you know of someone who meets the criteria, I could not thank you enough for passing along the information.

Please feel free to delete this post if it's not allowed. My sincere thanks for your consideration.

Ngā mihi,

Riley

Appendix D: Recruitment Flyer



Are you the father of a child with Borderline Personality Disorder?

I am looking for fathers of children (of any age) with borderline personality disorder (BPD) diagnosed over two years ago to participate in interviews which will explore your experiences. The data will be used for a Master of Science (Psychology) thesis at Massey University.

If interested, please contact:

Researcher: Riley Noonan,
@massey.ac.nz

Supervisor: Associate Professor Richard Fletcher, PhD, R.B.Fletcher@massey.ac.nz

Please scan the QR code for additional information on the study

TE KUNENGA KI PŪREHUROA
MASSEY UNIVERSITY
UNIVERSITY OF NEW ZEALAND

This research has undergone a peer review process and has been assessed as low risk. As a result, it has not been reviewed by Massey University's Human Ethics Committees. The researcher listed above is responsible for ensuring ethical research practices.

If you have any concerns about the ethical aspects of this research and would like to speak with someone other than the researcher, please contact Massey University Human Ethics by email: humanethics@massey.ac.nz.

Appendix E: Debriefing Sheet

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

Debriefing Sheet

Thank you for participating in this study. Your contribution to this research is greatly appreciated.

This study aimed to explore the experiences of fathers of children with Borderline Personality Disorder (BPD).

At the commencement of this research, there was no research on these fathers' experiences. It is hoped that this study will help to lay the foundation for subsequent research in the field and provide valuable information to inform support initiatives aimed at fathers of children with BPD.

Support Services

If you experienced any distress as a result of participating in this study or would like support, the following services are available in New Zealand:

- Need to Talk? 1737 – Free call or text 1737 to speak with a trained counsellor, available 24/7.
- Lifeline – Call 0800 543 354 for free, confidential support from trained counsellors.
- Samaritans – Call 0800 726 666 for access to a 24/7 crisis line for those experiencing loneliness, depression, despair, distress or suicidal feelings
- Skylight Trust – Provides support for those experiencing grief, loss, or trauma. Visit www.skylight.org.nz or call 0800 299 100.
- Yellow Brick Road – Provides support and information for family members of individuals experiencing mental illness. Visit www.yellowbrickroad.org.nz or call 0800 732 825.
- Parent Help – A confidential helpline for parents needing support. Call 0800 568 856.

Further Information

If participating in this research has raised any questions or concerns for you, please feel free to contact me or my supervisor. You can find our details at the end of this document.

Additionally, if you would like to receive a summary of the findings upon study completion, you may request this by emailing the researcher.

Thank you once again for your participation in this study.

Researcher: Riley Noonan, Master of Science (Psychology) student

Contact Information for the Researcher: [redacted]@massey.ac.nz

Supervisor: Associate Professor Dr. Richard Fletcher, PhD, School of Psychology

Contact Information for the Supervisor: R.B.Fletcher@massey.ac.nz

Appendix F: Interview Schedule

Introduction to Formal Interviews

Thank you for participating. I'm interested in understanding your personal experiences as a father of a child with Borderline Personality Disorder. There are no right or wrong answers. I'd just like to hear your perspective in your own words. While the events that occurred will be relevant to your experience, please note that I'm specifically interested in your experience, rather than a descriptive recount of your child's journey. We can pause anytime, and you don't have to answer anything you're uncomfortable with. Thank you for signing the consent form and indicating that you understand the participant information sheet. Do you have any further questions? Let's begin whenever you're ready.

Demographic Information

- Age
- Ethnicity
- Age of child
- Gender of child
- How long since child's diagnosis
- Any other mental health diagnoses

Core Interview Questions

Before Diagnosis:

- What was your life like prior to your child receiving a diagnosis?
- Were you in a relationship? Single dad?
    - Do you have any other children?
- What kind of relationship did you have with your child/wife/family?

- What kind of dad do you think you were?
- Did you notice your child becoming unwell prior to their diagnosis?
    - What was this like for you?
    - How did this affect you guys as a family?

During Diagnosis Period:

- Can you share how you first learned about your child's diagnosis?
    - What was that like for you?
    - How did you respond to receiving the diagnosis?
- How did you make sense of the diagnosis at the time?
    - (If had a partner): Do you feel you were both on a similar page or did you respond differently?
- What was your experience with the mental health system like?
    - Tell me about how it felt to navigate this system in the early days of your journey
        - Did this change with time or experience?

After Diagnosis:

- What is your relationship with your child like now?
    - How do you think this experience has shaped your relationship?
    - What kind of father do you think you are now?
- Has this experience affected other important relationships in your life?
    - If so, how? With whom?
- How have you managed to cope during this experience?
    - How did/do you look after yourself/get by?
    - What kinds of support, if any, have you sought during this experience?

  - What has been most helpful (or unhelpful) in terms of support?
    - Were there things you expected to help but didn’t?
    - Was there anything that surprised you after seeking help?
- If you could share something with other fathers going through this, what would it be?
- Looking back, is there anything you wish you’d known earlier?
- If you could design support specifically for fathers in this situation, what would it include?
- What stands out to you most when you reflect on this journey?

Closing

- Is there anything we haven’t discussed that feels important to you?
- Thank you for sharing your experiences with me. Your insights are incredibly valuable.
- If you feel that you need any further support after this interview, please don’t hesitate to get in touch with some of the services listed on the participant information sheet

Appendix G: Example Page from Reflexive Journal

Donovan 1st Interview

- Donovan was largely focused on talking about his daughter rather than himself
    - He would give indications to his experience
        - Brief adjectives like “hard, shocking” etc. but wouldn’t necessarily give much qualitative depth to his internal experience
    - I tried to probe this in several different ways, using sentences like “what was that like for you?”, “how did that feel?” etc., but it was difficult to access his internal word
- His daughter’s childhood and Donovan’s younger years as a father were a very long time ago though (30+ years), and Donovan did acknowledge that it was difficult to remember what he was thinking or what it was like
    - Potentially it’s too long ago to obtain real qualitative depth?
    - Maybe that’s ok?
        - We’ve been discussing the early years, pre-BPD, and this time largely just functions to get an idea of how things have changed since, and to provide a foundation to Donovan’s later narratives.
        - The richness and depth of experience is likely to emerge (and more important for it to) in the subsequent interviews
- Good rapport with Donovan
    - This interview was potentially the most organic feeling of all the participants
    - Either just practice effects from him being the last participant or our personalities get along well

Appendix H: Free Coding Example

Free coding	Transcript
L says putting up with the abuse and continually showing up was the hardest thing he's ever done. Unwavering commitment.	Leon: And I carried that that whole amount of time. And it was tough. It was the most hardest thing I've gone through in my life.
	Interviewer: I can only imagine. Yeah.
The rage wasn't humane. Unfair how horrible it was. Unpredictable. Comes from nowhere. Trying to handle the rage. Don't know what to do. Rejection of L - wants mum. Son appears unable to understand the perspective of other people. Blaming others, doesn't take accountability for self.	Leon: It was just, inhumane. It's just- so we would have him over for lunch and we'd take him out. We'd say, let's go out for a walk. We'd go for a walk and we're playing. And he's just playing. We went to some park and there was this thing you could stand in and run around like a rat thing. A mouse running on a wheel. And we started walking and then he just lost it. We're in the middle of nowhere in the street and he starts screaming and raging. And my partner and I are thinking, we've got to get out of here. But we're miles from the car. And we're "quieten down, quieten down, calm down, let's go, let's go". And we start walking back to the car and he's, "I want to go to my mum". No, you can't see your mother. "I want you to take me to my mum." No, you can't go to your mother. We took him home. He got an Uber and went straight to his mother's and got arrested. He went to [redacted] for breaching bail conditions and all that sort of stuff. And yet all through that he still didn't think he was doing anything wrong. It was her fault and all this sort of stuff. And it was a messy time. Very messy time. Yeah.
	Interviewer: How did you sort of make sense of all this, Leon, when this was going on?
Anti-diagnosis/labelling? What could this indicate?	Leon: I didn't. I didn't. You know what? I've never wanted to label my son.

Appendix I: Case-by-Case Coding Example

Phenomenological coding	Interview transcript	Emerging themes
First time hearing about suicidality quite shocking for S. K was ignoring him at this point - exacerbating feelings of disconnection and hopeless/uselessness that S was experiencing. Once they actually had opportunity to engage and connect, things improved quickly. K's MH improved as did S' anxiety and difficult emotions re sadness, uslessness etc. Difficult for S to notice - just felt K was more emotionally distant at times, slightly less talkative, harder to connect with. Distance/barrier re custody/ex made it much harder for S to notice the signs of BPD in K as he didn't really know her anyways. Desire to fix.	Simon: Oh, one time there, it was- she said something about Kathy being a bit suicidal. What? And I would ring her mother and talk to her mother a little bit. And yeah, and then once I talked to Kathy on the phone- because I'd ring her, I wouldn't get it. You know, she wouldn't answer the phone. But once I got her on the phone, yeah, things, yeah, fitted into a more manageable situation. Yeah. For her and me too, I suppose. Yes. Interviewer: Yeah. Did you ever see any of that in her when you were together? As in like, were there behaviours that you would see in person rather than hear from Diane? Simon: Yeah. Yeah, very slight, very slight behaviour things. She would sort of have a little bit of distance. You know? Interviewer: Yeah. Simon: And then come back again. Yeah. But it's hard for me because I don't- I didn't have any understanding of her. Yeah. You think, oh, yeah, okay. How do I fix this?	Custody arrangement made supporting difficult, harder to help Communication helps both S and K Difficult to notice BPD pre-diagnosis due to distance in relationship Desire to fix

Appendix J: Case-by-Case Emerging Themes to Superordinate Themes Process

Initial Emerging Themes

- Challenges due to complexity of son’s condition
- Difficulties with diagnosis
- Concerns over future
- Frustration with MHS
- Inconsistency/messiness with MHS
- Conflict with ex regarding differing parenting approaches
- Feeling lost as a dad
- Rejection by son
- Feeling unappreciated/used
- Impact on partner
- Trying your best while lost
- Hard to change your core self
- Can’t connect with son in ways L wants/knows how to
- Father/son connection is eternal
- Impact of upbringing on L’s parenting style
- Lack of identity
- Emotionally absent father
- One-way traffic relationship
- Authority undermined as father (by both son and ex)
- Difficulties establishing and upholding boundaries
- Disdain for overpathologising

- Unwavering commitment to son (such as tolerating abuse)
- Attempts to connect ignored/rejected
- Left out (ex as barrier, MHS deferring to mother)
- Emotional toll of son’s abuse/rage
- Shock of seeing son’s unwellness fully for the first time
- Empathising with son, rationalising his behaviour
- Anxiety/hypervigiliance around son (don’t want to trigger him)
- Challenges with anosognosia
- Traumatising impacts of MHS
- Medication helps but son stops once out of hospital
- Impact on wellbeing
- Helplessness/powerlessness
- Tedium/repetitive nature of son’s dialogue
- BPD diagnosis was validating
- L’s grief moving into anger
- Cycle of relapse - no proper solution
- Ongoing struggle to cope
- Impact on work
- Actively trying to heal
- Caring for an adult child
- Trying not to rescue son
- Loss of imagined relationship
- Alone/no-one understands

- Challenges with seeking support and sharing
- Positive individuals
- Barriers to son’s wellbeing
- Masculinity - desire to fix
- Masculinity - social norms re vulnerability and sharing
- Systemic MH issues
- Just want a listening ear, not advice

Reducing Duplicates, Grouping Conceptually-Related Themes, Condensing Slightly

Challenges due to complexity of son’s condition Difficulties with diagnosis Disdain for overpathologising Challenges with anosognosia Traumatising impacts of MHS Medication helps but son stops once out of hospital BPD diagnosis was validating Cycle of relapse - no proper solution Barriers to son’s wellbeing	Concerns over future Caring for an adult child	Frustration with MHS Inconsistency/messiness with MHS Left out (ex as barrier, MHS deferring to mother) Systemic MH issues	Conflict with ex regarding differing parenting approaches
Hard to change your core self Impact of upbringing on L’s parenting style Lack of identity Emotionally absent father	Rejection by son Feeling unappreciated/used Can’t connect with son in ways L wants/knows how to One-way traffic relationship Feeling lost as a dad	Impact on partner Emotional toll of son’s abuse/rage Shock of seeing son’s unwellness fully for the first time Anxiety/hypervigilance around son (don’t want to trigger him)	Father/son connection is eternal Unwavering commitment to son (such as tolerating abuse) Trying your best while lost

	Attempts to connect ignored/rejected Loss of imagined relationship	Impact on wellbeing Helplessness/powerlessness Tedium/repetitive nature of son's dialogue L's grief moving into anger Ongoing struggle to cope Impact on work Actively trying to heal Alone/no-one understands Challenges with seeking support and sharing Positive individuals Just want a listening ear, not advice	Empathising with son, rationalising his behaviour
Difficulties establishing and upholding boundaries Authority undermined as father (by both son and ex) Trying not to rescue son	Masculinity - desire to fix Masculinity - social norms re vulnerability and sharing		

Condensing Above to Remove Duplicates

- Frustration with MHS
    - Inconsistency/messiness with MHS
    - Left out (ex as barrier, MHS deferring to mother)
    - Systemic MH issues
    - Disdain for overpathologising
- Barriers to son's wellbeing:

  - Challenges with anosognosia
  - Traumatising impacts of MHS
  - Cycle of relapse - no proper solution
  - Challenges due to complexity of son's condition
- Conflict with ex regarding differing parenting approaches
- Rejection by son
  - Feeling unappreciated/used
  - One-way traffic relationship
  - Feeling lost as a dad
  - Loss of imagined relationship
- Impacts of son's illness
  - Psychological
    - Ongoing struggle to cope
    - Emotional toll of son's abuse/rage
    - Actively trying to heal
    - Alone/no-one understands
    - Shock of seeing son's unwellness fully for the first time
    - Anxiety/hypervigiliance around son (don't want to trigger him)
    - Helplessness/powerlessness
    - Concerns over future
  - Work
  - Relationship
- Challenges with seeking support and sharing

  - Positive individuals
  - Just want a listening ear, not advice
- Unwavering commitment to son (such as tolerating abuse)
  - Trying your best while lost
  - Empathising with son, rationalising his behaviour
- Difficulties establishing and upholding boundaries
  - Authority undermined as father (by both son and ex)
  - Trying not to rescue son
- Masculinity
  - Desire to fix
  - Social norms re vulnerability and sharing
- Minor themes (omitted from above table during condensing):
  - Caring for an adult child
  - BPD diagnosis was validating
  - Hard to change your core self
  - Impact of upbringing on L's parenting style
  - Lack of identity
  - Emotionally absent father
  - Attempts to connect ignored/rejected
  - Can't connect with son in ways L wants/knows how to
  - L's grief moving into anger
  - Tedium/repetitive nature of son's dialogue
  - Father/son connection is eternal

Clustering of Themes

- Frustration with MHS
    - Inconsistency/messiness with MHS
    - Exclusion
    - Systemic MH issues
    - Lack of holistic solutions
    - Emotional toll of MHS
- Conflict with ex regarding differing parenting approaches
    - Disdain for overpathologising
    - Difficulties establishing and upholding boundaries
    - Authority undermined as father (by both son and ex)
- Rejection by son
    - Feeling unappreciated/used
    - Feeling lost as a dad
- Impacts of son’s illness
    - Psychological
        - Ongoing struggle to cope
        - Emotional toll of son’s abuse/rage
        - Actively trying to heal
        - Alone/no-one understands
        - Shock of seeing son’s unwellness fully for the first time
        - Anxiety/hypervigiliance around son (don’t want to trigger him)
        - Helplessness/powerlessness

        - Concerns over future
    - Work
    - Relationship
- Challenges with seeking support and sharing
    - Positive individuals
    - Want support, not advice
- Unwavering commitment to son (such as tolerating abuse)
    - Trying your best while lost
    - Empathising with son, rationalising his behaviour
- Masculinity
    - Desire to fix
    - Social norms re vulnerability and sharing

Reworking Condensed Themes

- Powerlessness
    - Frustration with MHS
        - Inconsistency/messiness with MHS
        - Exclusion
        - Systemic MH issues
        - Lack of holistic solutions
        - Emotional toll of MHS
    - Inability to parent effectively
        - Conflict with ex
        - Difficulties establishing and upholding boundaries

        - Authority undermined as father (by both son and ex)
        - Desire to fix
        - Feeling lost and alone
- Unwavering commitment met with rejection
    - Feeling unappreciated/used
    - Tolerating abuse
    - Empathising with son, rationalising his behaviour
- Ongoing struggle to cope
    - Impacts on wellbeing
    - Actively trying to heal
    - Challenges with seeking support

Superordinate Themes

Powerlessness - Frustration with MHS/Inability to Parent Effectively

> Leon: I wanted to see that I'm an equal parent and that I deserve to be spoken to and to understand what's going on. Not secondhand through a nurse, you know, and then- or- and honestly, every single person you talk to- I mean, I would speak- I'd ring up the hospital daily. How's my son going? What's happening? You know, and, because you worry- because at the same time, I'm getting all the messages from him. “Dad, you've got to get me out of here. Dad, you've got to do something. Dad, you've got to do this. Dad, you've got to do that.” And I'm powerless.

Unwavering Commitment Met with Rejection

> Leon: Oh, I'm rejected. You know, I’m a- I feel- and this is part of the anger I'm feeling now, is that I was just used. I'm not even a- I don't think he really wants me as his father.

Ongoing Struggle to Cope

> Leon: I did not know how to cope with it. I did- because my love- I loved him. Then I- I would say it's almost like a woman who's being abused and goes back to the abuser. I felt that I was that. I kept going back to the abuser. And I loved him and I kept going back to him and getting abused. But kept coming back.

Appendix K: Cross-Case Theme Table with Examples

Superordinate	Subordinate	Leon	Simon	Donovan
Powerlessness and the limits of fatherhood	Frustrated agency	It's almost like you've got one chip to use. And if you use that chip, that's it. And my ex would use the chip, and I wouldn't have the ability to find out stuff. And that was really, really hard		
	Feeling useless and incapable		It was horrible. [...] And I just have to listen because [...] I just had no idea that this was like this, you know? It just explodes. And yeah, I just felt, okay, like, god… Yeah. It's not as if I could go throw the switch and fix it. You know?	
	Learning to support, not solve			I have been told more than once by Claire and Ava that I have a tendency to not really listen, but constantly looking for solutions.

				And that was not something that they necessarily enjoyed or found all that helpful, they found it frustrating. What they probably needed, or what they felt they needed, was somebody that would listen to the story, listen to what they were having to deal with without the father interrupting the story in terms of seeking solutions.
Commitment and connection (or lack thereof)	Unwavering commitment despite rejection	I've just journeyed through [...] hell for the last two years and you haven't even thought to contact me and reach out, no nothing. Am I really nothing to you?		
	Rediscovering connection		Well, that's what I've sort of always- you sort of try and strive for that. Well, they're your children, you know, you want that connection. Yeah, yeah. No, I'm at a point where I'm happy	

			with it	
	A united front			And it's just on a different level, the older that she got, but it was apparent that this wasn't something which was a childhood issue. It is a lifetime challenge that she has to deal with, and as a consequence, the family has to deal with.
Coping with the ongoing burden	Struggling to cope	I did not know how to cope with it. I did- because my love- I loved him. Then I- I would say it's almost like a woman who's being abused and goes back to the abuser. I felt that I was that. I kept going back to the abuser. And I loved him and I kept going back to him and getting abused. But kept coming back.		
	From distraction to engagement		What I would do is just get involved in doing. That's it, doing stuff. Yeah. Shit I could jump on one of my	

			motorbikes and go for a ride and just blow everything away and then just settle down, you know, I'd be sweet, you know?	
	Families need support too			And so I think that it's at a different level from those practitioners to be able to provide something which says, okay, here's an idea of what the condition is, what you can expect in terms of behaviourally and emotionally and so on. And possibly ways that you can assist, which is not to try and fix everything.
Making sense of BPD and renarrating fatherhood	Fatherhood in name only	I don't think he really wants me as his father.		
	Reconstructing fatherhood through connection		Like, okay, the horse has already bolted, but I can still have a good relationship with my daughter.	
	A different approach			And she spent a fair bit

				of her life hating herself. And you can't fix that for them. You can't change that for them. You have to enable them to do that by providing an environment and support so that they can feel well enough to make the changes themselves.