Helping mothers with the emotional dysregulation of borderline personality disorder and their infants in primary care settings

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Background

Six per cent of patients who present to primary care have borderline personality disorder (BPD). Mothers with full or partial features of BPD, often undiagnosed and perhaps previously functioning adequately enough on the surface, may rapidly become emotionally dysregulated by the normal needs of an infant. Family and maternal functioning can rapidly destabilise. Management of patients with BPD in primary care may be challenging.

Objectives

The objectives of this article are to provide primary care practitioners with relevant information on current knowledge of BPD and its management when mothers with BPD are caregivers to an infant.

Discussion

Useful guidelines for general practitioners that can help women who are emotionally dysregulated with infants include:

- keeping the diagnosis in mind
- openly discussing BPD diagnosis where relevant
- providing psychoeducational material and ongoing support to the woman and her family
- referring to specialised services for BPD
- referring to standard maternal–child health services and specialised infant mental health services
- ongoing communication with other services and supervision for the practitioner.

Although often undiagnosed, at least 6% of patients who present to general practice have borderline personality disorder (BPD).[1] The demands of caring for a small infant will prompt many new mothers to present for help. Some of these women may only partially fulfil BPD diagnostic criteria, but are overwhelmed by their emotions. This emotional regulation disorder (ERD) can often benefit from management that is similar to BPD management and, at times, general practitioners (GPs) may prefer to use such a term.

Infants need stability, predictability, someone who keeps them in mind and a great deal of urgent attention. When women have not mastered regulating their own emotions, helping an infant to settle may feel unmanageable, and a crisis rapidly develops. A mother with BPD/ERD may find infant care stressful, overwhelming and difficult to sustain, so the infant remains unsettled and the woman's confidence in parenting declines.

Certain BPD or ERD behaviours may be challenging for the GP, and the patient's behaviour can rapidly become difficult for all concerned (eg demands for special care from clinic staff and practitioner, obvious sensitivity to rejection, and sometimes angry outbursts).

There are very few general practice guidelines regarding the care of patients with BPD or ERD. When the woman has an infant, there are yet more complexities and even fewer guidelines, with very little research in this area. This article provides information amassed from general sources when working with patients with BPD, combined with approaches for perinatal women.[2]

Current concepts of causes and pathways for BPD

BPD was initially believed to be caused by childhood trauma, including sexual, verbal, emotional and physical trauma;[3] however, while many patients with BPD give this history, not all do. Newer

theories suggest that in some families, a parenting style that invalidates the emotions of their genetically sensitive children may be central to that child developing BPD.[4] The parents may have good intentions, but the frequent mismatch, or mis-attunement, is unhelpful for the child who grows up without a secure sense of self or knowing how to contain their own emotions.

Another recent analysis proposes that inconsistent parenting, varying from hostile control to avoidance and abandonment,[5] with parental emotional dysregulation, is central to future development of BPD. Without intervention or an excellent ability to reflect, the child may then go on to parent their children as they were parented, resulting in the intergenerational transfer of problems to their own children.

Extreme forms of BPD are well known and easily recognised: frequent presentations with suicidal thoughts and behaviours, rapidly fluctuating moods and interpersonal difficulties. There are those with BPD whose behaviours are more subtle and harder to pigeonhole, including mothers who externally have been able to function well despite their own inner emotional turbulence until pregnancy itself or infant care unravels their coping strategies.

Historically, the stigma of BPD, with its untreatability and poor prognosis, made recognition of this condition difficult. Precise diagnosis and open discussion are now more appropriate and helpful as several well-validated treatments (not all described here) have emerged,[6,7] including mentalisation-based treatment (MBT), which helps better parental reflection.

An ability to regard the infant as a separate person with their own needs, wants and emotions is beneficial for the infant, especially if the mother can reflect on how her own upbringing has influenced her views of her child and her parenting. Dialectical-behaviour therapy (DBT) is also well validated and, in its four modules, provides the mother with:[8]

- skills to calm herself by using mindfulness
- an understanding that distress is common and transitory (distress tolerance)
- skills to better regulate emotions
- ways to improve interpersonal relationships.

For mothers with BPD, these new skills combined with appropriate knowledge of parenting and infant development are theoretically beneficial, but little researched.

Presentations of mothers with BPD and their infants

Maternal presentations

Women with a history of suicide attempts, impulsive behaviours, interpersonal difficulties and other features of BPD may already be well known in some practices. Some women with BPD may begin to dysregulate in pregnancy if, for example, their body feels invaded, physical discomfort unsettles, memories of past sexual abuse are triggered, or partner problems are highlighted.[2] Domestic violence can increase at this time,[2] and compromised obstetric outcomes have been noted.[9]

Other new mothers with BPD may have had sufficient control of their emotions until postnatally, when they are presented with a crying infant who crowds their space, disturbs their sleep, makes constant demands and unintentionally stirs maternal emotions. Thus, functioning can unravel quickly. The woman or other family members may present for urgent help ('Doctor, I think I've got postnatal depression') when the woman has rapidly changing moods and often suicidal and infanticidal ideas and perhaps behaviours. Partner tensions can also be prominent at this time as the family moves to a state of despair.

Infant presentations

Most new mothers frequently seek help from their GP for a wide range of infant problems that are clearly related to physical health. Problems with feeding, sleeping and settling (the so-called regulatory problems) are also common presenting symptoms, perhaps more so for these families. A woman with BPD can find it difficult to provide sensitive 'good-enough' care to her infant around the clock as she struggles with her own inner turmoil. This can leave the infant without adequate help with settling and, therefore, unintentionally magnifying the problem.

Working with mothers with BPD who present for care in primary care settings

Making and giving the diagnosis

The nine criteria of BPD are readily accessible on many websites (eg see references 10 and 11). Accumulating and documenting relevant criteria over time have been recommended prior to a discussion with the patient about diagnosis. A GP's knowledge of family dynamics, history of abuse, or unexpected deterioration in function may be helpful in the early identification of BPD. Many physical comorbidities, including migraine and other headaches, chronic pain, obesity, chronic fatigue, and gastrointestinal disease, as well as psychiatric comorbidities, such as depression, anxiety, eating disorders and substance misuse, may help complete the picture.[12]

Once the GP believes BPD is likely, one approach to an agreed diagnosis is to use the nine criteria as a reference point. Each criterion can be framed as a question for the patient, using plain language (eg 'Do you think you make frantic efforts to avoid real or imagined abandonment?'). Women are generally able to understand the issues raised by these questions and openly discuss these issues. BPD is present if five or more of the nine criteria are validated; however, even with four, the emotional dysregulation is likely to be a problem for these women.

Most patients react with relief, and indeed gratitude, when provided with an open and kind discussion of BPD and potential pathways to improvement.

Many have long been aware that their emotional dysregulation is both extreme and intolerable to themselves and family members. Sadly, getting help may initially be challenging for some patients with BPD who are highly sensitised to rejection, and they will angrily decline therapy referral. This is likely to leave the GP not only as the main treating practitioner, but also with strong (and perhaps negative) feelings of their own.

Psychoeducation

Psychoeducation is now readily accessible on many good websites[13] and will be extremely useful to the woman if she accepts the diagnosis. It will also be helpful to her partner and extended family, if she allows family discussion.

Direct ongoing support

An essential aspect of care is validation of how the woman feels. Given a non-judgemental stance, she may respond to gentle exploration of her negative feelings, including sharing her feelings of inadequacy as a parent, self-hate and sometimes self-harming behaviours to relieve her inner tensions. The patient may describe her infant as demanding, or indeed hateful, and disclose fears of harming her child. Many such discussions are anxiety-provoking to the doctor, but can sometimes contain the situation for the patient.

Almost all mothers want and attempt to do the best for their infants. However, mothers with BPD may find it hard to tolerate their infant's distress, while also being vulnerable to anything that they interpret as critical or abandoning.[14] Thus, exploring difficulties in parenting may cause a patient to flee elsewhere, while her own and her infant's needs remain unaddressed.

Support will include clear boundary setting, use of a team approach where possible, with excellent communication between all members, validating the patient's feelings by naming them, and scheduling regular appointments that are not dependent on the patient being 'sick'.

Guidelines for general management include referral for psychotherapy (whatever is locally available) and restriction of medication.[15,16] There is no evidence that psychotropic medications provide long-term benefit. Sometimes, the demands for relief from the turmoil of crisis lead to attempts to obtain help through the prescription of antidepressant or antianxiety agents. If pressed to prescribe medication, make sure that the patient is aware of the short-term nature of medications, as well as the risks of overdose, dependence, unnecessary side effects and interactions with alcohol and other drugs.[15]

Risk management

In-depth exploration is necessary to ensure the risk of suicide, infanticide or significant infant harm are not imminent. If in doubt, take steps to ensure that protection of the child and mother are in place. Enquiring about domestic violence and substance use is worthwhile, with appropriate management strategies identified when either is volunteered. Family turmoil can be substantial, and ongoing emotional damage for other children in the house is possible. Some mothers with other children may manage their infant well, but find the on-the-go oppositional toddler unsettling and difficult to tolerate. More childcare can sometimes ease the situation.

Ensuring infant development and optimising parenting

GPs can ensure infant development and optimise parenting by:

- assessing physical development (ie infant weight, height, head circumference, skin colouration variation)
- attending to emotional development – ensure that the infant is provided help with settling and that exposure to maternal anger is minimised. How does the parent describe her infant? How does the infant respond to her?
- working closely with routine local maternal–infant settling services to minimise the likelihood of 'splitting' (ie idealising one practitioner and denigrating others), which is common between agencies when a patient has BPD.[17] Angry practitioners who each believe the other is wrong can result if inter-agency communication is problematic. Practitioners should beware when they receive praise from a patient who, at the same time, tells them about the incompetence of all the other professionals they see. A telephone call to others in the treating team may provide alternative views and bridges that can help all members of the treating team and, ultimately, the patient and their family.

Extended treatment for mothers with BPD

Referral may be appropriate despite the challenge of heightened sensitivity to rejection. Specialised services for patients with BPD can be difficult to access, as they may have long wait times and incur expenses. Nevertheless, helping patients to find appropriate therapies that provide potentially life-changing new skills and knowledge is worthwhile. New mothers are often highly motivated to do the best for their child and may therefore be willing to attend group or individual therapy.

Super-specialised services offering therapy for patients with BPD along with direct mother–infant intervention are being developed. Interventions that increase maternal sensitivity have been proposed,[18] as has behavioural parenting training.[5,19] Using parenting skills from established parent-training programs will be appropriate, especially when accompanied by maternal interventions such as MBT or DBT.[8]

Conclusion

There are many approaches for GPs to help mothers with significant emotional dysregulation. Further formal research on this topic is warranted, given the prevalence of BPD in primary care. Helping the mother also helps the developing infant and the whole family.

Self-care and reflective supervision are particularly important for GPs

when working with patients with often challenging behaviours, who are also primary caregivers to infants. While not universally available, Balint groups or other modes that encourage self-exploration and open expression enable practitioners to better handle troubled and needy families.[20]

Key points

- Keep the diagnosis of BPD in mind, and diagnose where appropriate with an open discussion with the patient regarding the nine criteria of this condition, noting that the diagnosis is made when five or more criteria are present.
- Watch the maternal–infant interaction to help think about effects of maternal turmoil that are already present in the infant.
- Provide good education about BPD to the woman and, where appropriate and acceptable, to family members.
- Validate how the mother is feeling, including both negative and positive aspects of her perceptions of herself and infant, and her parenting abilities.
- Discuss with the mother how she goes about settling her infant.
- Ensure risks (eg suicide and infanticide, domestic violence, substance abuse, concerns for other children) are identified, and safety appropriately addressed.
- Provide a secure base for the woman over time.
- Refer the mother to DBT, MBT or other validated BPD treatments, and ensure communication with all other professionals over time.
- Refer the mother to community services for helping to settle infants.
- Refer the mother and infant for parenting programs and/or specialised mother–infant therapy if available.
- Ensure cautious and judicious use of medications.
- Ensure practitioner self-care and reflective supervision.

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