Working with infants and their mothers with borderline personality disorder (BPD)

WA AAMHI presentation, October 2018
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What I are going to talk about tonight

- What is BPD – and where does it fit with other psychiatric diagnoses
- Incidence of BPD perinatally
- Intergenerational transfer of problems: Effects of BPD in patients, children and adolescents and what causes BPD
- Identifying targets to work with perinatal mothers with BPD and their infants
- Validation of BPD diagnosis
- Pathways to care from the maternal perspective in primary care settings
- Pathways to care from the infant perspective in primary care settings
- Specialised treatment pathways – MI-DBT (mother-infant dialectical behaviour therapy) – enlivened by video

Some generalities which guide my thinking

- All parents are doing the best they can
- Working perinatally is a time of high motivation to change in mothers and early intervention for infants
- Mostly parenting is "good-enough" albeit not perfect
- Sometimes it's not good enough and we need to invoke another system which tries to be good-enough – child protection services
- Give a man (me…) a hammer and all he sees are nails
- It is easy to love the baby and hate the mother
- Your system is different to the one I work in…
- But wherever we are and wherever we are working we have to work in teams, cooperatively, across systems, well-supervised
- And then about when exactly bringing up children well

The range of postnatal psychiatric problems: Old style

- The blues
- Puerperal psychosis
- Postnatal depression
- Postnatal anxiety

AND SO NOW…..INTRODUCING......

- THE QUEEN'S NEW CLOTHES!!

The range of postnatal psychiatric problems: New style

- The blues
- Puerperal psychosis
- Postnatal depression
- Postnatal anxiety
- Emotional dysregulation
- Borderline personality disorder
The panorama of emotional (dys)regulation

Normal emotions
Disorders of mood: PND and postnatal anxiety
Emotional dysregulation and Borderline personality disorder

So what is emotional dysregulation?

• An emotional response which is poorly controlled and does not fall within the conventionally accepted range of emotive response
• “Losing it”
• Having a meltdown down!
• We can all have meltdowns. It is the scale and frequency and other symptoms that might mean someone has traits or full borderline personality disorder - BPD

WHAT IS BPD?
A VERY BRIEF REVIEW

• Originally Kernberg: the borderline between psychosis and neurosis
• In essence from my point of view, EMOTIONAL DYSREGULATION with its behavioural consequences underpinned by changes at the brain level - and given that the most frequent cause of emotional dysregulation is interpersonal friction and mothers are with PERSONS almost all the time (INFANT AND/OR PARTNER) –
• or maybe even their mother-in-law, inevitably there is a lot of emotional dysregulation
• Professor Louise Newman: A failure of parental MENTALISATION/REFLECTIVE FUNCTIONING
• 9 Characteristics as defined in DSM IV

What is BPD (DSM IV & V) (and with an infant)

• frantic efforts to avoid real or imagined abandonment
• a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
• identity disturbance: markedly and persistently unstable self-image or sense of self
• impulsivity in at least two areas that are potentially self-damaging
• recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
• affective instability due to a marked reactivity of mood
• chronic feelings of emptiness
• inappropriate, intense anger or difficulty controlling anger
• transient, stress-related paranoid ideation or severe dissociative symptoms

Hindbrain: Basic Life Function
Midbrain: Emotions (the Amygdala) Memory Movement
Forebrain: Thinking

The beauty of the panorama

Other than the obvious
New classification of bundling all personality disorders together
Many of the patients we see have mixed personality features which run them into problems eg...
Narcissistic personality disorder!
INFANT MOTHER

BABY CRIES AND SENDS SIGNAL TO MOTHER FROM MIDBRAIN

MUJ WANTS TO HELP AND LOOKS AT HER INFANT

Adrenal gland

REGARD R

BUT VERY SOON MUM'S ANXIETY OVERWHELMS AND SHE MOVES INTO RUPTURE INTO HER MIDDLEBRAIN WHERE SHE CAN ONLY EMOTE, NOT THINK

IMPACT OF BPD IN PREGNANCY
Pare-Miron (2016) and Blankley et al (2015)

• Gestational diabetes
• Premature rupture of the membranes/requests for early delivery
• Chorioamnionitis
• Venous thromboembolism
• Consequences of substance abuse
• Preterm infants/more special care nursery

The impact of BPD on infants: the research

• Kiel (2011): mothers initially sensitive but sensitivity decreases, infant cries longer as doesn’t feel validated--INFANT CLEARLY DOES NOT FEEL VALICATED, MOTHER MOVES INTO HER MIDDLEBRAIN WHERE SHE CAN ONLY EMOTE, NOT THINK – EFFECTS OF INFANT ON MOTHER AND MOTHER ON INFANT
Gratz (2014): Disorganised attachment, frightened infant, self-absorbed mother w abnormal neuro-regulatory pathways
• SUMMARY: MANY PROBLEMS HOVING INTO VIEW
Impact of BPD on infants: the consequences
Making up is hard to do: Apter et al
- Minor stress disorganizes infants
- Minor stress disorganizes infants of women with BPD
  - More consistency in her response so infant does not learn agency = “when I act in a certain way I learn that the world responds in a predictable way” so becomes anxious/insecure
  - The mother may be perceived as inconsistent, repetitively intrusive and unpredictable so the asynchrony between mother and infant continues
    - she often moves from underinvolvement (disengaged, hostile) to overinvolvement (guilt-ridden, confused boundaries, meeting her needs through infant)

Therefore infant trusts less well so reunions for BPD dyads will be harder
- and this is for a woman with potentially less ability/a greater tendency to dysregulate so it will keep a rapidly developing vicious cycle going

So by the time the infant moves into childhood…

What happens to mothers of infants?
(Geerling 2017 unpubl)
- “Mothers with BPD entered motherhood in a psychologically fragile state, hypersensitive to experiencing intense physiological-emotional pain and cognitive chaos in response to infant crying.”
- “Automatic maladaptive flight-fright responses including suicide attempts were common. A novel theme revealed some mothers split identity, and only the ‘mother’ part could attend to infant crying”.
- “detrimental domino effect on close family”
- Mothers aware of gaps in accessibility of current mental health services and parenting programs
- want to prevent the intergenerational transmission of attachment problems and BPD symptoms to offspring

PROBLEMS CAUSED BY BPD:
Child and young adult outcomes

VERY POOR OUTCOMES AT EVERY STAGE WITH PROBLEMS IN LEARNING, AND HIGHER INCIDENCE OF PSYCHIATRIC PROBLEMS IE INTERGENERATIONAL TRANSFER OF PROBLEMS

- Macfie and Swann (2009): 4-7 y olds show shame, hostility, fear of abandonment
- S. Stepp (2011): a large number of internalising and externalising behaviours
- Winsper (2012): 11 yr olds: cognitive deficits, parental conflict
- Barnow (2006), Herr (2008): psychiatric, emotional, interpersonal difficulties
- Lyons Ruth (2012, 2013): BPD intergenerational transfer of problems in young adults especially with maternal avoidance

- What about the effect of the infant on the mother?

Summary: Problems caused by (innocent) infant to BPD mother
- People with BPD (traits) may generally be less reflective and/or prone to move quickly from forebrain to midbrain ie from thinking to feeling and then behaving:
  - We can only think with our forebrains and emote with our midbrains.
- So when her baby cries, she initially tries to help but if infant doesn’t respond quickly mother becomes emotional/dysfunctional eg withdraws (Kiel). Does she then become depressed so diagnosed as depressed as she is very aware of problems with her parenting competence?
- Obviously by the time the infant is a toddler, there is well-established VICIOUS CIRCLE
  - Mother means well, knows she is troubled, doesn’t have a name for her condition, skills to reflect and calm down SO SHE/THEY ARE IN STRIFE WHEN INFANT IS BORN – ANTENATAL IDENTIFICATION AND PSYCHOEDUCATION/TREATMENT COULD BE BENEFICIAL!

WHAT CAUSES BPD?

- TRADITIONALLY: SEVERE CHILDHOOD ABUSE OF ALL SORTS: EMOTIONAL, VERBAL, SEXUAL, PHYSICAL
- INTERGENERATIONAL TRANSFER OF PROBLEMS FROM MOTHER WHO IS FRIGHTENED AND FRIGHTENING (Mary Main and Eric Hesse)
- MORE RECENTLY: EXQUISITE SENSITIVITY (PROBABLY GENETIC) TO INVALIDATING STYLES OF PARENTING –PERHAPS MANY OF OUR PTS

INCIDENCE

- PND: 15% of postnatal women
- Emotional dysregulation – unknown – many many new mothers in the first several weeks/months postnatally
- BPD in the community – 1 - 6%
- BPD in general inpatient psychiatric units: 12 - 20%
- BPD in Helen Mayo House: 47% by McLean self-report (still 40% at discharge), 11 % primary clinical diagnosis, 11% comorbid with depression
- And how much research is there on perinatal BPD????
NEWS FLASH! MORE PUBLICATIONS APPEARING!

• ANTENATAL: JUDD ET AL, OCTOBER 2018, ANZJP

• A total of 200 patients who had completed the Edinburgh Postnatal Depression Scale were seen for assessment. 86 (43%) scored ≥13 on Edinburgh Postnatal Depression Scale. Of those scoring ≥13 or more on Edinburgh Postnatal Depression Scale, 22 (25.6%) had a depressive disorder. In total, 12 patients (14%) had an anxiety disorder, 14 (16.3%) had borderline personality disorder and 13 (15.1%) had a substance use disorder. An additional 23 women (26.7%) had two or more borderline personality traits.

• POSTNATAL

1. MARIA MUIZ ET AL, MARCE SOCIETY CONFERENCE SEPT 2018
2. MARGARET HOWARD SEPT 2018, MARCE SOCIETY
3. PROF BRIN GRENYER, OCTOBER 2018, SYDNEY – PARENTING WITH BPD

Making the diagnosis of BPD

• Beginning to understand that “borderline” personality structure may be present and that PND may not explain all that is present
• Work through your own stigma and that of your colleagues – an appropriate diagnosis may be most helpful for the patient
• Work through the criteria of BPD with the patient where appropriate or seek help from a relevant colleague
• If diagnosis is present, discuss with the person in an open way

And then what?

• Provide mother and her family with psycho-education about her condition and include partner and family as far as Mum allows
• Assess safety concerns (suicide/infanticide)
• Don’t see medication as the cornerstone of treatment
• And how do others conceptualise targets for working with perinatal BPD

What the literature shows us about how to intervene – other people’s ideas

1. STEPP et al: Extreme inconsistency from over-involvement to under-involvement – SO THEY RECOMMEND ADDRESSING THIS FRAME – perhaps we do this already by providing DBT
2. Zalewski: Use evidence from the literature and target behaviors rather than the attachment relationship directly – behavioral parenting methods and parental emotional regulation skills
3. Lyons-Ruth: Use evidence-based parenting programs
5. Lighthouse program – Parental reflective functioning is addressed
6. (Nancy Suchman: Parenting from the Inside Out) – parental reflective functioning – for substance-abusing mothers

SUMMARY: MANY DIFFERENT IDEAS
All our thinking summarized: mother perspective

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

Sved Williams A, Apter G, 2017, Australian Family Physician Volume 46, No.9, September 2017 Pages 669-672 (Open access)

• Give her information about how to parent her infant
• Observe the mother-infant interaction and always keep the infant in mind – remember effects of infant crying on mother!
• Help her along a pathway to diagnosis and treatment eg with Mother-infant dialectical behavior therapy (MI-DBT) or other programs eg playgroups, parenting from the inside out
• Intervene as a therapist to help her with herself – support, validation eg use of BATHE technique
• More in involved as a therapist to help her with her baby – RRRR
• Better help for staff: more education eg DBT training, reflective supervision.
• Ensure help for family – PROJECT AIR – University of Wollongong, Australia.

All our information summarized: infant perspective

The infants of emotionally dysregulated or borderline personality disordered mothers: issues and their management in primary care.

Apter G, Sved Williams A, Australian J General Practice, 2018, 47(4) 200-203

• Keep the infant in mind!
• Make sure infant physical and emotional development appropriate to age
• Use strengths based approaches which are evidence based and may include developmental and interactional guidance
• Involve family members where possible to help with child care and/or use paid child care
• Provide information about normal infant development and use maternal-child health services where possible
• Use specialized services if available eg mother-infant therapists
• Use child protection services where necessary

THE BATHE TECHNIQUE

• B - What is the Background to your problem
• A - How Are you feeling (Affect)
• T – What is Troubling you the most
• H – How are you Handling it?
• E – an Empathic reply “that must be hard for you”

Mum’s formula: RRRRR

Rupture – parent becomes upset
Re-Move – move away from problem
Re-mind – gives herself space to be MINDFUL – using relaxation/mindfulness
Re-flect – moves back into her forebrain and THINKS ABOUT A STRATEGY TO RE-ENGAGE
Re-pair – moves back with infant to help infant calm

ENSURE MOTHER FEELS VALIDATED – REMEMBER SHE MAY/HAS BEEN INVALIDATED IN CHILDHOOD!

REMOVE RR

BUT VERY SOON MUM’S ANXIETY OVERWHELMS AND SHE MOVES INTO RUPTURE ie into her midbrain where she can only feel, not think

RE-MIND MINDFULNESS RR

SO SHE NEEDS TO CALM DOWN: RE-MIND, DO SOME MINDFULNESS
Marital/partner issues

- Keep partner in the loop
- Or right out of the loop if relevant...
- Provide psychoeducation if possible
- Involve in therapy where acceptable

- And grandparents etc where relevant

Family life is STRESSFUL

- It is very important to ask about domestic violence aka IPV = interpersonal violence
- 36% of women experience DV
- 22% experience in pregnancy
- ¼ of those for first time when pregnant

- NB conversely, sex in pregnancy...

And a small word about grandparenting...

- Guess what characteristics do NOT work for grandparents?
  - CRITICAL
  - INTRUSIVE

So translating the words about grandparenting...

- So always be the “opposite”: Validating, available

- Well, good-enough grandparenting exists I guess
General principles summarised

- Keep THE PANORAMA in mind
- If you can help that diagnosis to happen, and then find a pathway that looks after the maternal dysregulation AND the parenting/mother-infant
- ALL interventions that help both of those aspects are likely to be useful albeit evidence is thin
- The best guidance is that treating maternal depression without intervening with the mother-infant relationship does NOT change infant outcomes although the mother may be helped (in the short term)
- SO MAKE SURE TO ASK HOW THE MUM FEELS TOWARDS HER BABY AND REMEMBER LAFS EXPERIENCES (LOVE AT FIRST SIGHT – JOHN CONDON) AND VALIDATE HER CONCERNS

SO NOW MOVING TO HOW WE TREAT PERINATAL BPD

Firstly – our book!

- What it’s about
- Costs $15
- Buy it from wchfoundation.org.au/meltdownmoments

What’s the book about?

PICTURE STORY FOR 0-6 year olds AND THEN SOME PSYCHOEDUCATION FOR FAMILY MEMBERS

WHAT WE DO: DIALECTICAL BEHAVIOR THERAPY FOR MOTHER AND INFANT: MI-DBT

- MINDFUL PARENTING (Coyne and Murrell)
- DISTRESS TOLERANCE – EXAMPLES/HOMWORK ALWAYS BASED AROUND WOMAN AS A MOTHER – SHARK MUSIC AND CONCEPTS FROM CIRCLE OF SECURITY
- EMOTIONAL REGULATION: INCLUDES DEVELOPMENTAL GUIDANCE FROM LYNNE MURRAY, THE PSYCHOLOGY OF BABIES
- INTERPERSONAL SKILL TRAINING

NEARLY FINISHED

- THIS IS WHAT THE QUEEN LOOKS LIKE IN HER NEW CLOTHES! (POST TREATMENT FOR HER EMOTIONAL DYSREGULATION!)
Sonya’s story

- Ran away from home aged 9 because of abuse, violence
- Child protection services involved with several foster homes
- Worked in clubs, met a partner, followed him to NZ and became pregnant with twins. Moved back to Adelaide
- Emotionally dysregulated in pregnancy
- At twins aged 6 months, admitted to our inpatient unit determined to adopt her babies
- Decided she couldn’t so…

After therapy

- Not a magic cure
- But – wow!!

Our results: Moving from...

- From intolerable to manageable!

Beck Anxiety

Edinburgh Depression Scale

Borderline symptom list
McLean Screening Instrument for BPD

Parenting sense of competence

Parental Reflective Functioning Q
Pre-mentalising modes

PRFQ: Interest and curiosity in mental states

CARE Index: mother-infant relationship
(changing to NCAST)

THE END! And QUESTION TIME