

# Improving the attachment relationships of mothers with borderline personality disorder (BPD) and their infants

## And a few other comments!

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# My talk

1. What happens to infants whose mothers have BPD/Emotional Regulation Disorder (ERD)
2. What happens to mothers with BPD/ERD when they have babies
3. How do these mother-infant dyads present for help
4. How do we go about helping them?
5. And.. A little bonus – moving our thinking from “depression” to “emotional dysregulation”!!

# First, a definition of attachment

Attachment is one specific dimension of the relationship between child and parent which is involved with making the child feel safe, secure and protected

OR NOT – as in the case of some infants whose mothers have BPD

# 1. Effects of BPD on infants

- Different attachment relationships discernible in the first few weeks (Kiel), and often well-locked in by twelve months (Steele and Siefert, Hobson and Crandell)
- Intergenerational transfer of problems – mental health difficulties in children (Stepp, Winsper, Barnow) and young adults (Lyons-Ruth)
- General pattern: **Inconsistent** parenting characterised by **over-involvement** (over-protective and inhibiting autonomy eg in toddlers) **to underinvolvement** (disengaged, hostile, less sensitive, guilt-inducing) and overall, maladaptive patterns including boundary confusion and role-reversal especially as infant grows) (Eyden, Stepp)

## 2. Effects of infants on BPD mothers

- In pregnancy: remarkably few studies (Blankley (2015), Pare-Miron (2016))
- Postnatally, first wave – those women who cannot tolerate their infants crying
- Second wave – those women who cannot tolerate the “abandonment” of their infants when the infants become mobile

# Effects of infant crying on mothers

(Geerling 2017 unpubl recent Masters)

- “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”

## So Ingrid's recommendations:

- Antenatal BPD screening:
- psychoeducation about infant crying
- greater access for programs supporting the whole family to improve outcomes



### 3. How do these women present for help?

- **Via the mother:** eg In my perinatal and infant service/mother-baby unit. “This mother has postnatal depression. She is suicidal and has an unsettled baby”!
- **Via the infant:** Unsettled babies: the whole gamut of sleep/feeding/settling problems – NB mothers with BPD find it VERY hard to settle an infant
- Occasionally from mental health workers/GPs who know the mother has BPD and it is effecting her parenting competence and her infant/relationship with her infant

## 4a. How we help dyads who present with maternal BPD – **INPATIENT PHASE**

- **Early diagnosis** – we work through the 9 criteria from DSM with the women
- Provide **psychoeducation** to woman and her family – including internet sites eg Project Air
- **Ward protocol** – 2 week admission, precise discharge date, package of referrals on discharge (average 4, 2 for mother, 2 for dyad/infant)
- **Staff have education** in working with BPD and also **reflective supervision**

# Understanding mother's need: RRRR

**Rupture** – parent notices her upset and distances

**Re-mind** – gives herself space to be **MINDFUL**

**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

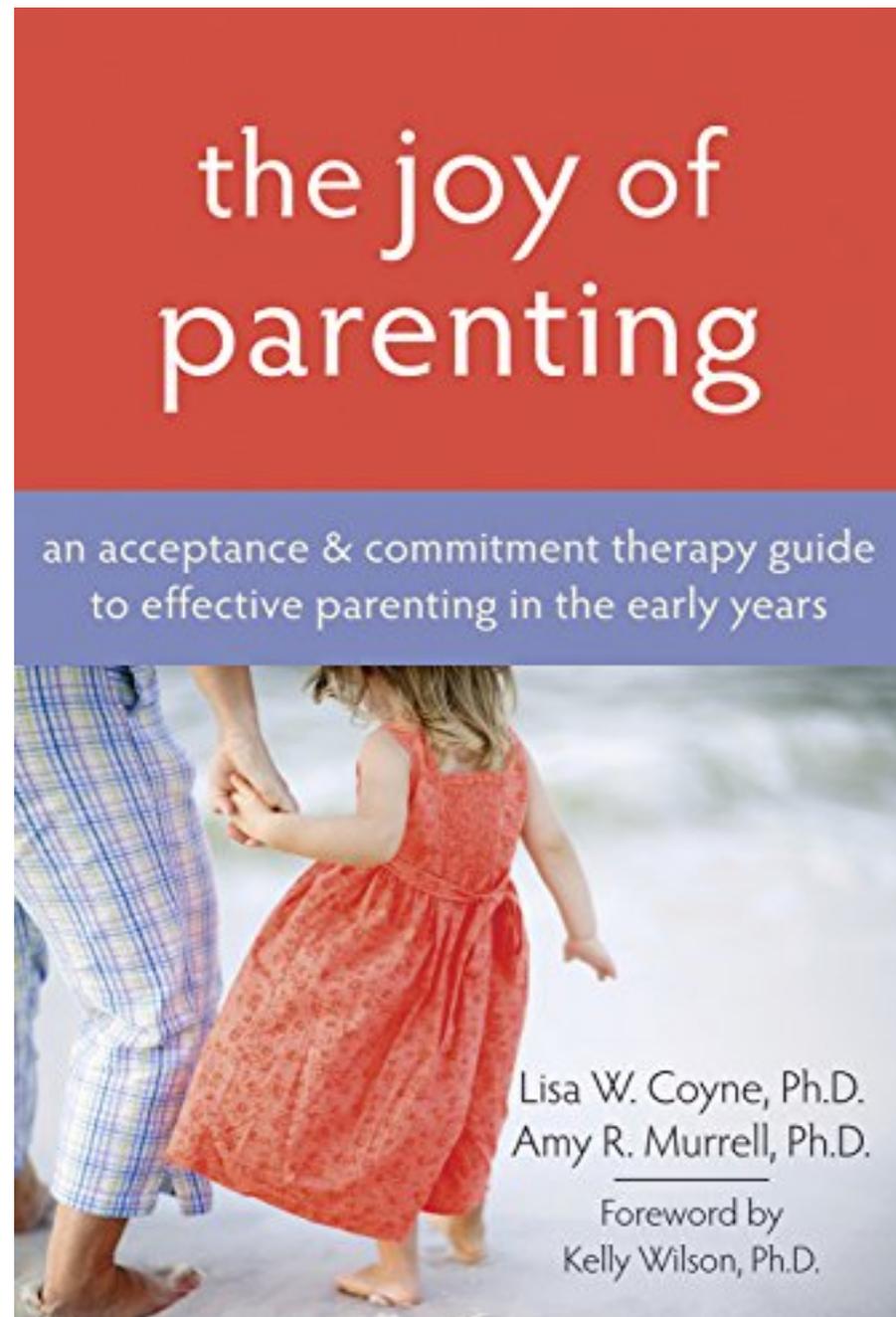
## 4b. How we help dyads who present with maternal BPD – Out/Pt PHASE

- Referral for **MI-DBT: Mother-Infant Dialectical behavior therapy**
- **An adapted DBT with a total focus on parenting and dyadic relationships, child care for infants, reunion activities**
- Still pilot but now on our fifth run
- 12 dyads per group, and a rapidly growing waiting list
- 29/45 women (64%) accepted and commenced MI-DBT. 21 (72%) have completed at least one full 26 week course, with full data available on 20 of these.
- Submitted for publication

## MI-DBT: Module One

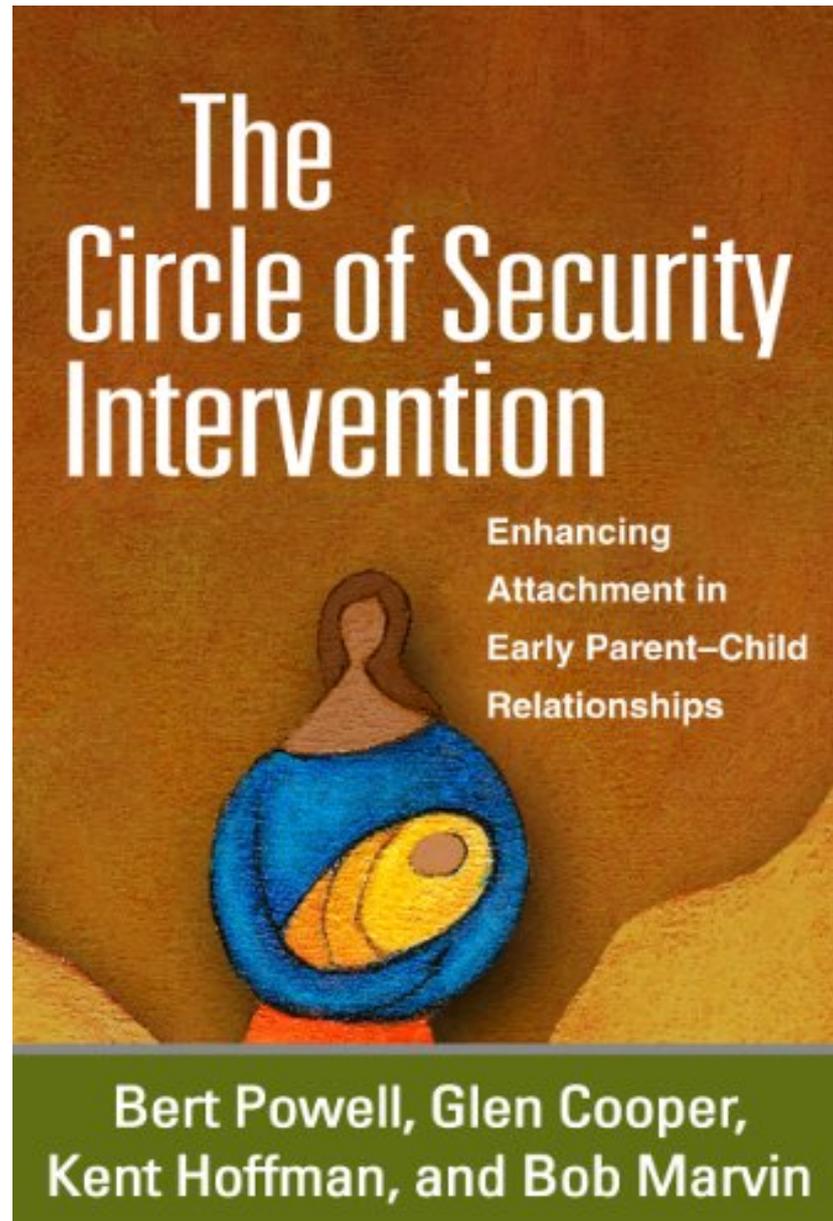
### Mindfulness –

incorporating ideas on  
Mindful Parenting  
from *The Joy of  
Parenting* by Coyne  
and Murrell



**MI-DBT: Module TWO**  
**DISTRESS TOLERANCE**

INCORPORATING  
IDEAS FROM THE  
CIRCLE OF SECURITY,  
PARTICULARLY SHARK  
MUSIC



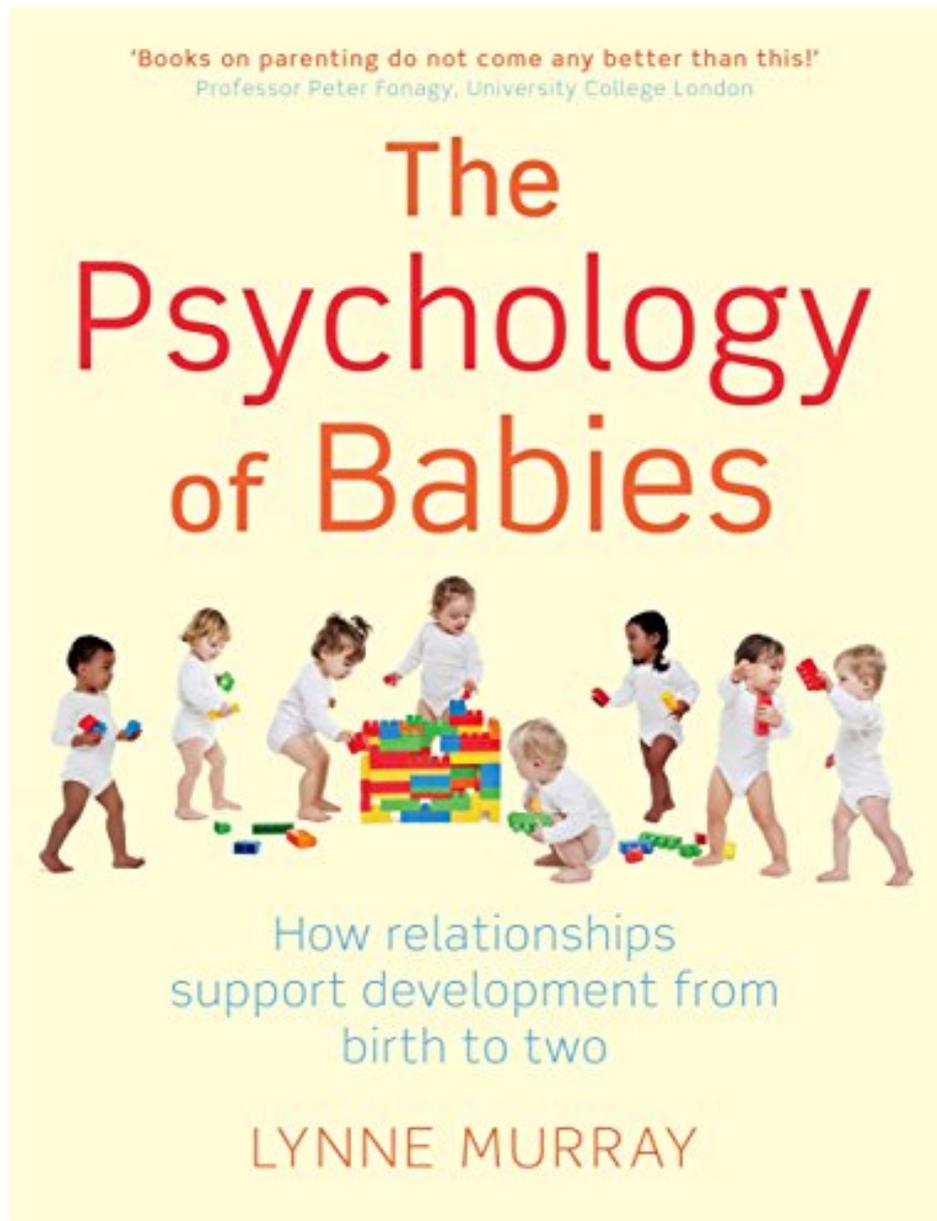
## MI-DBT: Module III

### Emotional regulation

Lynne Murray:

The Psychology of  
Babies

Chapter : Self-  
regulation and control



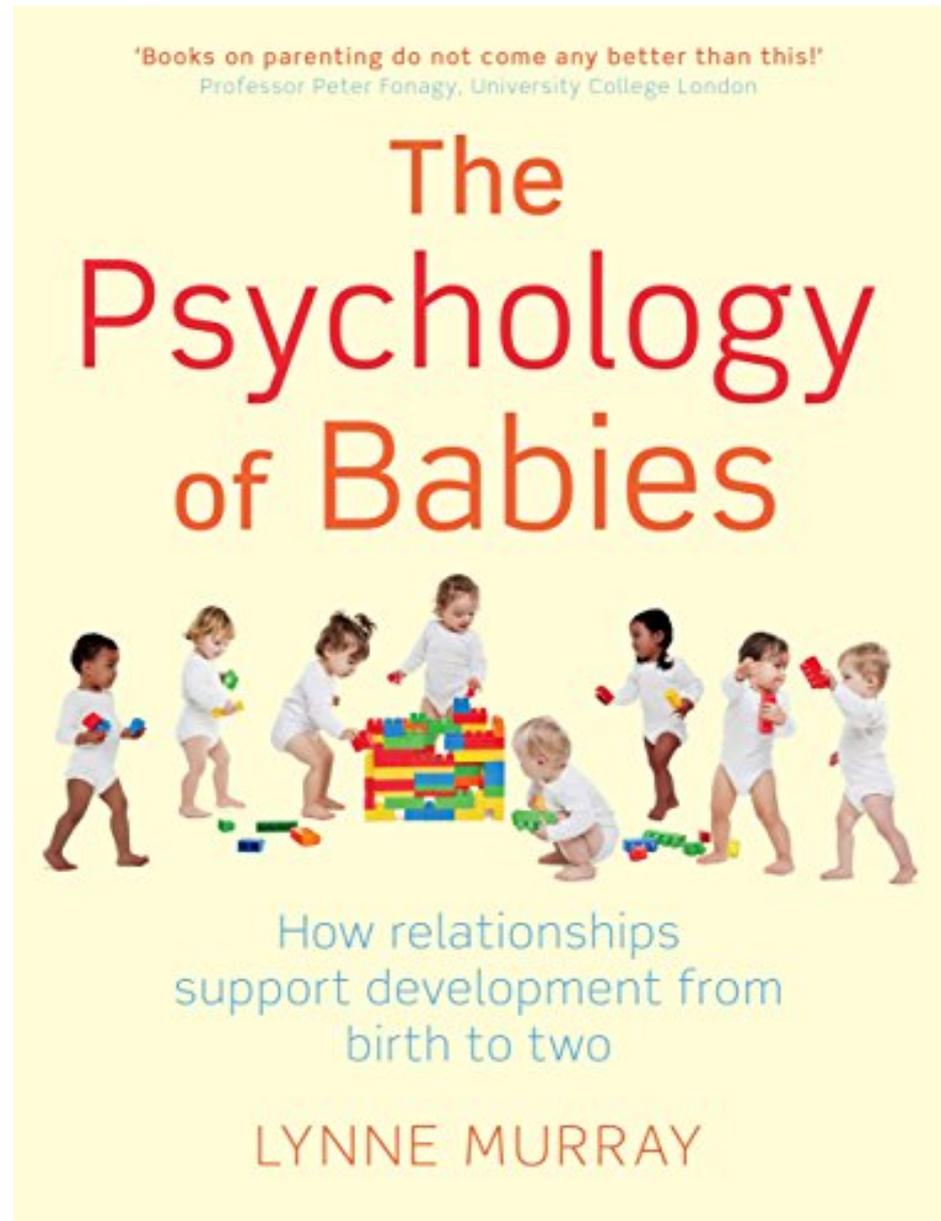
## MI-DBT: Module IV

### INTERPERSONAL EFFECTIVENESS

Lynne Murray:

The Psychology of  
Babies

Chapter: Social  
understanding and  
cooperation



## DOES IT WORK? SUMMARY OF WORK WITH OUR FIRST 20 PATIENTS

McLean Screening Instrument for  
Borderline Personality Disorder (MSI-  
BPD): **SIGNIFICANTLY IMPROVED**

Borderline Symptom List 23(BSL-23)  
(Short version): **SIGNIFICANTLY  
IMPROVED**

Edinburgh Postnatal Depression Scale  
(EPDS): **SIGNIFICANTLY IMPROVED**

Beck Anxiety Scale (BAS): (Beck et al,  
1988). **SIGNIFICANTLY IMPROVED**

Parenting Sense of Competence Scale  
(PSOC): Equivocal – only added later  
so results only on 12 patients

The Parental Reflective Functioning  
Questionnaire (PRFQ) : **SIGNIFICANTLY  
IMPROVED**

- And the piece de resistance: Care Index
- The median Care Index score increased from 4 to 6, indicating a significant improvement on this scale.
- This included 10 dyads who moved from the “at risk range” to inept or adequate
- So here is an individual story.. Sonny and her twins

# CONCLUSIONS

- **Qualitative:** Mothers LOVE our program and clearly learn and their infants benefit – interviews currently being analysed
- **Quantitative:** improvements in maternal mental health, reflective functioning and dyadic relationship – early promise of disruption of intergenerational transfer of problems from mother to infant
- **Attachment relationship:** improved as mother becomes more predictable, less intrusive, less frightening
- But this is a pilot program and we need to move further

# NEXT STEPS

- Next phase will have a waiting list control, blinded raters, more attention to what happens in the childcare room and more input to dyadic reunions
- Our results are highly encouraging for these women and we believe that helping mothers with their emotional dysregulation as well as focusing on reflective parenting to improve the dyadic attachment relationship is appropriate and also likely to be of benefit to a huge range of dyads whose mothers are currently diagnosed with PND

# AND MUSINGS...

- BPD is extremely common in psychiatric populations and 23% (clinical diagnosis)-48% (self-report inventory) of our mother-baby unit have this diagnosis
- As mentioned, most come in with a diagnosis of PND but we believe that putting the BPD/ERD diagnosis on the table is appropriate
- And for all those young researchers out there, there are 10 publications on PND for every one on BPD (taking into account comparative prevalence rates of 1/15)!

# References

- [Effect of \*\*Borderline Personality Disorder\*\* on Obstetrical and Neonatal Outcomes.](#)
- Pare-Miron V, Czuzoj-Shulman N, Oddy L, Spence AR, Abenhaim HA.
- Womens Health Issues. 2016 Mar-Apr;26(2):190-5. doi: 10.1016/j.whi.2015.11.001.

# References

- Berthelot N, Ensink K et al, Intergenerational transmission of attachment in abused and neglected mothers: the role of trauma-specific reflective functioning. *IMHJ*, 2015, 36(2) 200-12
- Blankley G et al, BPD in the perinatal period: early infant and maternal outcomes, *Australasian Psychiatry*, 2015, 23(6), 688-692
- Pare-Miron V et al Effect of BPD on obstetrical and neonatal outcomes, *Womens Health Issues*, 2016, 26(2), 190-195