

# Infants of emotionally dysregulated or borderline personality disordered mothers

## *Issues and management in primary care*

Gisèle Apter, Anne E Sved Williams

### Background

Knowledge has increased regarding the developmental needs and capabilities of infants, and parental behaviours that support optimum infant development. Despite a better understanding of the emotional dysregulation in borderline personality disorder (BPD) and its effects on infants, general practitioners have had few guidelines for how to recognise and help emotionally dysregulated mother–infant dyads.

### Objectives

This article focuses on the behaviours and needs of infants whose mothers have BPD, including knowledge and skills for primary care practitioners to help these troubled families.

### Discussion

Understanding the adequacy of parenting and troubling infant signs, such as hypervigilance, can potentially lead to either more intervention in primary care, including support, reassurance, guidance regarding development and interaction, and enhanced family support or else specialist referral for enhanced infant care. Infants' needs are urgent, and timely intervention can begin a better life trajectory for infant and mother.

**A GROWING BODY** of research in the rapidly developing field of infant mental health is focusing on understanding and better managing the effects of maternal depression (postnatal depression) on the fetus,<sup>1</sup> infants<sup>2</sup> and children.<sup>3</sup> Borderline personality disorder (BPD) is comparatively much less studied, although 6% of people attending primary care may have BPD.<sup>4</sup> General practitioners (GPs) are likely to see women at the perinatal stage with BPD, especially as BPD may be comorbid with postnatal depression.<sup>5</sup>

This infant-focused article describes the recent understanding of normal infant development and the accumulating evidence of the intergenerational effects of BPD on children.<sup>6</sup> We also highlight emerging pathways to help infants in families with BPD. A recent article<sup>7</sup> focused on these mother–infant dyads from a maternal aspect.

### Infant emotional development and parenting

Infants are keen to interact. Normal, full-term infants are ready to explore and communicate from birth. When babies are days old they will prefer parental smiling and cooing with exaggerated emotional expression to other forms of interactive play. As weeks go by, infant smiling can be triggered, the infants' interactions become more explorative, and their intentions more visible as they seek novel environments to explore. The mother guides her infant with her voice and with her reactions to what her infant is studying; mother and infant both monitor each other through gazing to interpret new stimuli:

*Is it safe?*

*Should I move towards this new experience or person, or hide behind you?*

*Can you guide me and let me know whether we approve?*

This wonderful, innate interactional capacity makes infants ready partners in transactions, and exquisitely sensitive to their first and foremost caregiver, preferring human faces and voices, and specifically their mothers,<sup>8,9</sup> who are their main caregiver in most cultures. Fathers, grandparents and others increasingly have a role as primary caregivers but have been relatively little studied so are not the primary focus here.

Helpful concepts for understanding maternal BPD and infant relationships include:

- Winnicott's<sup>10</sup> concept 'good enough': clinicians need to observe 'good-enough' parenting, which helps children with basic physical needs and provides emotional safety and care, and with consistent limit-setting.
- Rupture and repair: Tronick confirmed that good-enough mothers will tune into their infants sometimes, but certainly not all the time, using different mechanisms to identify with their infant's needs. They can move from 'rupture' in the relationship to 'repair' by a variety of mechanisms.<sup>11</sup> They explore strategies for soothing the infant, respond adequately and in a timely manner, and set rhythms and patterns that will give the infant a sense of self and agency. Tronick's 'still face'

experiments elaborate how a young infant quickly learns their good-enough mother's predictable responses, and shows alarm when these responses are unexpected ([www.youtube.com/watch?v=apzXGEbZht0](http://www.youtube.com/watch?v=apzXGEbZht0)). If too inconsistent in their parenting, BPD mothers may not achieve 'good enough'.

Several authors have proposed that the inconsistencies of behaviours are the most challenging for infants.<sup>6,12</sup> Maternal BPD<sup>13</sup> through an infant's eyes could be experienced as confusing and frightening ('inappropriate intense anger or difficulty controlling anger'), or stifling ('frantic efforts to avoid abandonment').

### The documented effects from pregnancy to young adulthood

Retrospective case reviews of women diagnosed with BPD in obstetric settings found frequent requests for early delivery, high comorbidity with substance abuse and compromised birth outcomes, compared with other births in the same hospitals.<sup>14,15</sup>

Mothers with BPD show differences in parenting style from birth onwards,<sup>16</sup> and their infants show the effects of these differences:<sup>6</sup>

- By the age of three months, infants may cry for longer and may relate differently to their mothers,<sup>6</sup> and mothers may find it difficult to interpret their infants' facial expressions.<sup>17,18</sup>
- By the age of 12 months, when infants' attachment patterns to their caregivers can be reliably measured, there are higher percentages of 'disorganised attachments',<sup>19</sup> meaning that infants respond at reunion with their mother without a coordinated strategy to help their distress to a brief separation; such patterns are known to be associated with fear, trauma and inconsistent parenting.
- Longitudinal studies<sup>6,20,21</sup> show intergenerational transfer of problems from mother to offspring well established in childhood, with internalising (often mood changes) and externalising (conduct disorders and behavioural difficulties) problems.
- By the time these children have grown up, higher rates of mental illness, and

BPD in particular, are found, although there is insufficient research to quantify precisely.<sup>6</sup>

### Observations in the consulting room

Perinatal mental health clinicians working with BPD dyads (personal communication) have noted:

- The infant may appear hypervigilant or stressed. Frozen expressions and a limited aptitude to visually explore the environment are concerning signs.
- The infant may be 'glued' to the mother's face, while the mother glances back and forth. The infant seems to be attempting regulation of the mother rather than vice versa.
- When a mother is overwhelmed by her own emotions, her focus is herself and her inner turmoil. Gazing at her infant may diminish and her narrative is less about her infant's needs and her ability to help her infant.
- The mother may be hesitant in settling her crying infant – she may not have skills to settle herself.<sup>6,21</sup> At other times, she may meet her own needs for closeness with intrusive behaviours to her infant. Guilt regarding her angry outbursts at her infant may colour her conversation in the consulting room.
- Many women with BPD describe painful memories of how they were parented, leaving them without clear templates of how to optimally parent their own infant.

### Infant-focused work with mothers with BPD

The professional's role is to simultaneously understand and help the infant and the mother. Infants need general care that is adequate and safe, and at least one person who is sufficiently attentive to help them learn the essential skills of settling and emotional regulation.

The mother's emotional regulation and availability to her infant will be augmented by kindly support from her caregivers, who focus on her strengths and abilities as well as recognising her distress and mood swings.

Infant-focused steps that GPs can take include the following:

- Undertake a full physical examination of the infant, including observation of developmental milestones and age-appropriate play. Ensure the mother's expectations of her infant are developmentally appropriate – many parents may lack knowledge about how best to help their infant explore the world and seek comfort when appropriate. The Circle of Security,<sup>22</sup> well known to maternal-child health practitioners, offers an excellent diagram regarding infant needs to help structure this discussion. Questions that elaborate on the mother-infant relationship can also be useful.<sup>23</sup> For instance, 'How are you feeling towards your baby?', 'Do you have thoughts of harming your baby?', or 'Did you get the baby you expected?'
- Assess whether parenting is 'good enough' for the infant's needs<sup>10</sup> and whether onward referral is necessary. The five-item FEVAR Scale of Matthey and Guedeney<sup>24</sup> (Facial expression, Eye gaze, Vocalisation, Activity level and Relationship with examiner) provides a structured framework to think about the infant. Each of these five items is scored 0 if the infant appears normal on this parameter (eg vocalisations are heard at an age-appropriate level in the consulting room); 1 if uncertain (for instance a physically sick infant may be quieter than usual or else crying in pain); and 2 if clearly abnormal, particularly if problems are noted over more than one visit. An infant scoring a total of 2 or more out of 10 warrants at least ongoing observation and reassessment during further work with the mother and family, and onward infant-focused referral if concerns continue.
- If relatively reassured by the above, support the mother in what she does well. Work with maternal-child health services (infant support) and perhaps a mental health practitioner (maternal support and skills with emotional regulation).<sup>7</sup> Use 'interactional guidance'<sup>25</sup> – encouraging a mother to observe and do more of what she is already doing well. A strengths-based approach with questions that focus on

how far the woman has come in her life (eg 'How have you managed so well in your life prior to becoming a parent?') provides reassurance, validation and support. It will help the mother to know she has done the best for her child, and that her own issues and past history do not have to be repeated. Enhancing her infant's development provides scaffolding for the mother, promotes her parental competence and thereby heightens her self-esteem.

- If mothers are significantly emotionally dysregulated, the infant is likely to be struggling. The dyad needs further help. Consider involving other family members to ensure that the woman has more support and a break from parenting duties, and that the infant has other caregivers and experiences. Good paid childcare can work well.
- Referrals to a range of services that can carry out direct work with the infant and mother–infant dyad include:
  - routine child health services
  - evidence-based therapies for the mother's personality-related issues,<sup>26</sup> including dialectical behaviour therapy
  - super-specialised therapies that include helping the mother's emotional dysregulation, sensitivity and reflective capacity, as well as the dyadic relationship, are currently being developed,<sup>27,28</sup> and may be available in some areas. As the maternal oscillations between under-involvement and over-involvement with her infant<sup>6</sup> may be particularly challenging for the infant, these therapies, which help the mother to understand and change this style, may be useful.<sup>29,30</sup>
  - if concerned about infant safety, for instance if significant physical harm has occurred to infant or the mother voices infanticidal ideation, notification of child protection agencies is necessary. Ongoing verbal and emotional abuses are harmful to the infant. Acknowledging and addressing these issues of safety are necessary and can lead to better care for the whole family.

## When things do not go according to plan

The personality fragility of some women with BPD may lead to angry responses if concerns about their infant are perceived as being critical of their parenting, and they may refuse further help, leaving the professional with confused and angry feelings.

Infant safety must remain a priority alongside sensitive care of the mother.<sup>7</sup> Infants develop rapidly and cannot wait indefinitely for good quality parenting. Recalling that women want to be the best parent they can may be a common focus for professional and parent and help to move through ruptures in the professional relationship to repair. This may enable ongoing appropriate care for infant and mother together or separately, reaching out for the 'good enough' for both in these challenging situations.

## Key points

- Ensure a focus on both mother and infant perspectives.
- Ensure appropriate physical and emotional infant development. Use developmental and interactional guidance when parenting is 'good enough'.
- Use a strengths-based approach to address maternal problems of emotional dysregulation openly and with understanding, and validating the mother's concerns.
- Involve other family members. Paid childcare may help.
- Refer mother and infant to normal parenting services, and local mental health practitioners. Two-way communication with other services is important.
- Consider specialised mother–infant services.
- Involve child protection services when necessary.

## Authors

Gisèle Apter MD, PhD, Presidente SIP, Chair Child and Adolescent Psychiatry, Groupe Hospitalier du Havre, University Rouen-Normandie France, gisele.apter@gmail.com

Anne E Sved Williams MBBS, FRANZCP, DipPsychother, Medical Unit Head, Helen Mayo House, Perinatal and Infant Mental Health Services, Women's and Children's Health Network, SA; Clinical Senior Lecturer, Department of Psychiatry, University of Adelaide, SA. Anne.SvedWilliams@sa.gov.au  
Competing interests: None.

Provenance and peer review: Not commissioned, externally peer reviewed.

## References

1. Gentile S. Untreated depression during pregnancy: Short- and long-term effects in offspring. A systematic review. *Neuroscience* 2017;342:154–66. doi: 10.1016/j.neuroscience.2015.09.001.
2. Hoffman C, Dunn DM, Njoroge W. Impact of postpartum mental illness upon infant development. *Curr Psychiatry Rep* 2017;19(12):100. doi: 10.1007/s11920-017-0857-8.
3. Letourneau NL, Dennis CL, Cosic N, Lindner J. The effect of perinatal depression treatment for mothers on parenting and child development: A systematic review. *Depress Anxiety* 2017;34(10):928–66. doi: 10.1002/da.22687.
4. Gross R, Olsson M, Gameroff M, et al. Borderline personality disorder in primary care. *Arch Intern Med* 2002;162(1):53–60.
5. Apter G, Devouche E, Gratiot M, Valente M, Nestour AL. What lies behind postnatal depression: Is it only a mood disorder? *J Pers Disord* 2012;26(3):357–67.
6. Eyden J, Winsper C, Wolke D, Broome MR, MacCallum F. A systematic review of the parenting and outcomes experienced by offspring of mothers with borderline personality pathology: Potential mechanisms and clinical implications. *Clin Psychol Rev* 2016;47:85–105. doi: 10.1016/j.cpr.2016.04.002.
7. Sved Williams A, Apter G. Helping mothers with the emotional dysregulation of borderline personality disorder and their infants in primary care settings. *Aust Fam Physician* 2017;46(9):669–72.
8. DeCasper AJ, Fifer WP. Of human bonding: Newborns prefer their mothers' voices. *Science* 1980;208(4448):1174–76.
9. Sai FZ. The role of the mother's voice in developing mother's face preference: Evidence for intermodal perception at birth. *Infant Child Dev* 2005;14(1):29–50. doi: 10.1002/icd.376.
10. Winnicott DW. Transitional objects and transitional phenomena; A study of the first not-me possession. *Int J Psychoanal* 1953;34(2):89–97.
11. Tronick EZ. Emotions and emotional communication in infants. *Am Psychol* 1989;44(2):112–19.
12. Stepp SD, Whalen DJ, Pilkonis PA, Hipwell AE, Levine MD. Children of mothers with borderline personality disorder: Identifying parenting behaviors as potential targets for intervention. *Personal Disord* 2011;3(1):76–91.
13. Project Air. Project Air Strategy for personality disorders. Wollongong, NSW: University of Wollongong. Available at [www.projectairstrategy.org/index.html](http://www.projectairstrategy.org/index.html) [Accessed 10 March 2018].
14. Blankley G, Galbally M, Snellen M, Power J, Lewis AJ. Borderline Personality Disorder in the perinatal period: Early infant and maternal outcomes. *Australas Psychiatry* 2015;23(6):688–92. doi: 10.1177/1039856215590254.

15. Pare-Miron V, Czuzoj-Shulman N, Oddy L, Spence AR, Abenham HA. Effect of Borderline Personality Disorder on obstetrical and neonatal outcomes. *Womens Health Issues* 2016;26(2):190–95. doi: 10.1016/j.whi.2015.11.001.
16. Delavenne A, Gratier M, Devouche E, Apter G. Phrasing and fragmented time in 'pathological' mother-infant vocal interaction. *Musicae Scientiae* 2008;12(Suppl 1):47–70. doi:10.1177/1029864908012001031.
17. Apter G, Devouche E, Garez V, et al. The still-face: A greater challenge for infants of mothers with borderline personality disorder. *J Pers Disord* 2017;31(2):156–69. doi: 10.1521/pedi\_2016\_30\_243.
18. Elliot RL, Campbell L, Hunter M, et al. When I look into my baby's eyes . . . infant emotion recognition by mothers with borderline personality disorder. *Infant Ment Health J* 2014;35(1):21–32. doi: 10.1002/imhj.21426.
19. Hobson RP, Patrick MP, Hobson JA, Crandell L, Bronfman E, Lyons-Ruth K. How mothers with borderline personality disorder relate to their year-old infants. *Br J Psychiatry* 2009;195(4):325–30. doi: 10.1192/bjp.bp.108.060624.
20. Genet MC, Valérie G, Emmanuel D, Marina V, Annick LN, Apter G. Motherhood of women with borderline personality disorder and interaction with their children: Longitudinal perspectives in motherhood, mother-baby's interaction, attachment and emotional regulation of the children. *Eur Child Adolesc Psychiatry* 2015;24(Suppl 1):1. doi:10.1007/s00787-015-0714-4.
21. Lyons-Ruth K, Bureau JF, Holmes B, Easterbrooks A, Brooks NH. Borderline symptoms and suicidality/self-injury in late adolescence: Prospectively observed relationship correlates in infancy and childhood. *Psychiatry Res* 2013;206(2–3):273–81. doi: 10.1016/j.psychres.2012.09.030.
22. Marvin R, Cooper G, Hoffman K, Powell B. The Circle of Security project: Attachment-based intervention with caregiver-pre-school child dyads. *Attach Hum Dev* 2002;4(1):107–24.
23. Sved Williams AE. Early parent-infant attachment. What can the GP do to help? *Medicine Today* 2001;2(9):71–77.
24. Matthey S, Črnčec R, Guedeney A. The modified ADBB (m-ADBB): Assessing for infant withdrawal during routine examinations. Sydney: South West Area Health, 2005. Available at [www.scribd.com/document/288019947/The-Modified-ADBB-Assessing-for-Infant-Withdrawal-During-Routine-Examinations](http://www.scribd.com/document/288019947/The-Modified-ADBB-Assessing-for-Infant-Withdrawal-During-Routine-Examinations). [Accessed 26 January 2017].
25. McDonough S. Interaction guidance: Promoting and nurturing the caregiving relationship. In: *Treating parent-infant relationship problems: Strategies for intervention*. Sameroff A, McDonough S, Rosenblum K, editors. New York: Guilford Press, 2004; p. 79–96.
26. Cristea IA, Gentili C, Cotet CD, Palomba D, Barbui C, Cuiipers P. Efficacy of psychotherapies for borderline personality disorder: A systematic review and meta-analysis. *JAMA Psychiatry* 2017;74(4):319–28. doi: 10.1001/jamapsychiatry.2016.4287.
27. Newman L. Parents with borderline personality disorder – Approaches to early intervention. *Australas Psychiatry* 2015;23(6):696–98. doi: 10.1177/1039856215614988.
28. Sved Williams A, Yelland C, Hollamby S, Wigley M, Aylward P. A new therapeutic group to help women with borderline personality disorder and their infants. *J Psych Pract* 2018 (in press).
29. Letourneau N, Tryphonopoulos P, Giesbrecht G, Dennis CL, Bhogal S, Watson B. Narrative and meta-analytic review of interventions aiming to improve maternal-child attachment security. *Infant Ment Health J* 2015;36(4):366–87. doi: 10.1002/imhj.21525.
30. Wright B, Hackney L, Hughes E, et al. Decreasing rates of disorganised attachment in infants and young children, who are at risk of developing, or who already have disorganised attachment. A systematic review and meta-analysis of early parenting interventions. *PLoS One* 2017;12(7):e0180858. doi: 10.1371/journal.pone.0180858.

correspondence [ajgp@racgp.org.au](mailto:ajgp@racgp.org.au)