Borderline Personality Disorder: Maternal Practices and Possible Parenting Interventions

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Abstract
Seventy-five percent of individuals diagnosed with borderline personality disorder (BPD) are women. Many of these women are also likely to be mothers and, considering the extensive functional impairments associated with BPD, probably experience many difficulties parenting. However, there is little empirical attention towards the effects of BPD on maternal practices, and the development of treatment for such women. Furthermore, given that parenting impacts both mother and child, and that maternal BPD places children at risk for exhibiting emotional, and behavioural problems, developing a parenting intervention for this high-risk population is important. Accordingly, there are three objectives for this research review. First, past literature pertaining to parenting practices and behaviours of mothers with BPD will be examined. The review will demonstrate that parenting behaviours include intrusively insensitive and affectively dysregulated comments and behaviours, as well as role confusion, disorganized verbal, emotional, and behavioural expressions, and less structured interactions with their children. Next, given that interventions for mothers with BPD and their children do not exist, attachment-based and psychoeducation-based interventions—which address improving parent-child relations regardless of diagnoses—will be compared and contrasted. Finally, strategies for developing a parenting intervention for mothers with BPD will be discussed.

Mental illness can severely impact the interpersonal functioning of afflicted individuals. This especially includes their parenting capabilities and relationships with their child. Some of these individuals may meet the criteria for borderline personality disorder (BPD). Theoretical accounts and clinical conceptualizations of BPD highlight significant impairments in self-functioning, such that afflicted individuals experience severe disturbances in identity or self-direction (American Psychiatric Association, 2013). Additionally, the lack of empathy, intense and unstable relationships marked by mistrust, neediness, preoccupations with real or imagined abandonment, and extremes of idealization and devaluation characterize these patients’ interpersonal problems (APA, 2013). Finally, symptoms of BPD also include negative affectivity (i.e., emotional liability, anxiousness, separation insecurity, and depressive symptoms), disinhibition (i.e., impulsivity and risk-taking), and antagonism (i.e., hostility; APA, 2013). Given their emotional and interpersonal impairments, individuals with BPD are likely to face poor social, occupational, and academic outcomes (Bagge et al., 2004) and have erratic treatment utilization patterns (Levy, 2005).

In clinical settings, 75% of individuals diagnosed with BPD are women (Skodol & Bender, 2003). In the United States alone, over 6 million women are possibly diagnosed with BPD (Friedel, 2004) and a large number of these women might also be mothers. Given the extensive functional impairments associated with this illness, they may face parenting difficulties that could negatively influence their relationships with their children. Thus, it is surprising that, unlike other mental illnesses (e.g., depression and anxiety disorders), the effects of maternal BPD on parenting practices have received little empirical attention or treatment development efforts. Furthermore, previous research suggests that from infancy to early adolescence, maternal BPD places children at risk for a range of emotional and behavioural problems. These include attention deficit hyperactivity disorder, higher rates of BPD symptoms (Feldman et al., 1995), as well as attention problems, delinquency, and aggression (Barnow et al., 2006). As a result of these findings, and the fact that parenting
impacts both the mother and the child, developing a parenting intervention that targets this high-risk population is an important endeavor. Accordingly, there are three objectives in this empirical review. First, a review of past literature on parenting practices and behaviours among mothers with BPD will demonstrate that mothers’ parenting behaviours consist of intrusively insensitive, and affectively dysregulated comments and behaviours, role confusion, disorganized verbal, emotional, and behavioural expressions, and less structure during interactions with their children. Then, given that interventions designed specifically for mothers with BPD and their children do not exist, attachment-based and psychoeducation-based interventions will be compared and contrasted. In conclusion, strategies for developing a parenting intervention for mothers with BPD will be discussed.

Parenting Practices and Behaviours among Mothers with BPD

According to Linehan’s (1993) biosocial theory, BPD is a pervasive dysfunction of the emotional regulation system caused by the transaction of biological, temperamental, and environmental factors. The role of invalidating rearing environments—perpetuated by mothers with BPD—is a major construct of this theory, yet remains unexamined in this specific population. An invalidating rearing environment is characterized by a deficit in the environmental support necessary to help emotionally vulnerable children learn how to regulate their emotions. This environment may involve abuse, punishment, neglect, denial, or trivialization of emotional experiences, and oversimplification of affect (Linehan, 1993). In normative samples, parental invalidation of children’s emotions is associated with emotional and social difficulties in early childhood (Eisenberg, Fabes, & Murphy, 1996), and psychological distress in adulthood (Krause, Mendelson, & Lynch, 2003). As a result of their own upbringing in emotionally invalidating environments, mothers with BPD may also invalidate their children’s emotions, especially if they inaccurately perceive these emotions. In turn, this may lead their children to deny or question their own feelings and affective responses. Furthermore, based on Linehan’s (1993) conceptualization of invalidating rearing environments, the enduring invalidation of emotional experiences may disrupt the development of adaptive emotion regulation strategies. Unfortunately, these potential roles of emotional invalidation among mothers with BPD have not been empirically investigated.

Empirical investigations on mothers with BPD have, however, examined this population’s parenting behaviours with the use of the still-face paradigm. This paradigm consists of a mother maintaining eye contact with her infant without vocalization, facial expression, or expressive gestures (Tronick, Als, Adamson, Wise, & Brazelton, 1978). It was adopted to assess how mother-infant dyads manage a situation of emotional difficulty and conflict (Crandell, Patrick, & Hobson, 2003). In one study, eight mothers with BPD and 12 healthy controls were videotaped interacting with their 2-month old infants in three successive phases of interaction: two minutes of ‘normal’ face-to-face free play; a 90-second episode where the mother adopted a ‘still-face’; and a two minute period where the face-to-face free play resumed. Mothers with BPD were more likely to be characterized as intrusively insensitive (i.e., hostile, rejecting, unresponsive, and demanding) based on ratings of their speech and behaviours during both the free play period before the ‘still-face paradigm, and the recovery free play period afterwards (Crandell et al., 2003). These findings were replicated in a new sample of 10 infant-mother dyads afflicted with BPD (Hobson, Patrick, Crandell, García-Pérez, & Lee, 2005). Given the meticulous diagnostic screening methods, the small sample size was the primary methodological limitation of both studies; however, these groups of mothers with BPD and their infants are the largest studied so far. One plausible reason for this limitation are the problems of identifying and recruiting mothers with BPD who have very young infants.

The ways in which mothers with BPD engage with their 12-to-18-month-old infants during separation-reunion episodes has also been examined. Hobson et al. (2009) videotaped mother-infant interactions in
separation-reunion episodes in the ‘strange situation’ test, which examines the attachment patterns exhibited between mothers and infants in response to separation, and reunion periods (Ainsworth & Bell, 1970). Masked ratings (i.e., the raters of the videotapes were unaware of the participant diagnoses and the overall nature and predictions of the study) of maternal behaviours were made pertaining to disrupted forms of maternal affective communication (e.g., fear, hostility, and anxiety) with their infant. As compared to mothers with depression, and mothers without a psychopathological disorder, a higher proportion of women with BPD displayed dysregulated affective communication and more frightened and disoriented behaviours toward their infants (Hobson et al., 2009). The participants in this study were not representative of the broader range of individuals with BPD; however, given that the majority of mothers with BPD did not suffer from a comorbid disorder, the study’s findings likely reflect maternal characteristics associated with the diagnosis of BPD alone. Overall, these findings provide substantive support for the perspective that individuals with BPD, who manifest clinical features, such as impulsivity, self-damaging behaviours, and affective instability, also have troubled patterns of affective communication, and relatedness within their relationships with significant others (Hobson, Patrick, & Valentine, 1998). In this particular example, mothers with BPD exhibit such troubled patterns with their infant.

Consistent with findings from observational studies with infants, role-reversals (i.e., the child takes on a parental role, for instance, by telling their fighting parents to stop and go to their room) are more common among mothers with BPD and their 4-to-7 year old children than in healthy controls (Macfie & Swan, 2009). Moreover, an overall maladaptive caregiver-child relationship (as self-reported by the child) is associated with maternal identity disturbance and self-harm (Macfie & Swan, 2009). According to the researchers’ interpretations of these findings, a child begins to develop a sense of autonomy at the beginning of early childhood; however, mothers with BPD, who prefer that the child stay close to them to circumvent the abandonment fears that occur in BPD, might discourage this developmental milestone. This may result in role-reversal, whereby the child takes on an adult role of a peer, friend, or parent (Macfie & Swan, 2009). Additionally, this type of interaction can be characterized as emotional over-involvement in that it inhibits the child’s autonomy in order to meet the mother’s emotional needs.

Mothers with BPD may also find it difficult to balance appropriate limit-setting with the encouragement of exploration and growth for their children. For instance, Bezirganian et al. (1993) reported examples of perceptions that mothers with BPD had about their 6-to-16 year old children. In one example, a mother reported that she wished to place her son in the freezer so that he could never grow old enough to leave her. She also described how she would pout and plead for his company (especially when he was invited to go out with his friends), but still let him socialize (Bezirganian, Cohen, & Brook 1993). These interactions were characterized as inconsistent and disorganized, because the mother’s verbal and emotional expressions conveyed one meaning, but the result of the interaction conveyed another. In line with this interpretation, disorganized attachment during infancy—a frequent outcome for infants of mothers with BPD (Hobson et al., 2005)—has been shown to predict role-reversals with toddlers (Macfie, Fitzpatrick, Rivas, & Cox, 2008) and young children (Main, Kaplan, & Cassidy, 1985).

Research on parenting practices of mothers with BPD also includes assessments of parenting perceptions. First, mothers with BPD were found to be less sensitive, and demonstrated less structuring in their interactions with their infants in comparison to psychologically healthy mother-infant dyads (Newman, Stevenson, Bergman, & Boyce, 2007). Accordingly, infants of mothers with BPD were found to be less attentive, interested, and eager to interact with their mother (Newman et al., 2007). Mothers with BPD also perceived differences in their parenting ability, reporting to be less satisfied, competent, and more distressed relative to psychologically healthy mothers (Newman et al., 2007). Interestingly, Newman et al. (2007) suggested that the levels of distress and perceived difficulties with parenting roles might contribute to neglect and abuse. Neglect, abuse, and emotional under-involvement by caretakers—extreme forms of environmental and emotional invalidation—correlates with, and contributes to the development of BPD (Bornvalova, Gratz, Delany-Brumsey, Paulson, & Lejuez, 2006). For example, chil-
In sum, parenting patterns among mothers with BPD include insensitive and affectively dysregulated forms of communication such as intrusive, hostile, rejecting, demanding, unresponsive, and frightening comments and behaviours. Additionally, these mothers are likely to engage in role confusion with their children, whereby their child takes on the role of a parent or friend. Moreover, parenting practices are also characterized by inconsistent and disorganized verbal, emotional, and behavioural expressions by mothers. Finally, mothers with BPD are likely to have less structure in their interactions with their children and to report high levels of distress and difficulties in roles as parents, which could lead to abuse out of frustration, and hopelessness. The clinical implications of these findings include considering whether an intervention should be designed to foster more optimal mother-infant relations or to support the afflicted mothers specifically.

**A Comparison between Attachment- and Psychoeducation-based Interventions**

The reviewed studies suggest that maternal parenting strategies among mothers with BPD are characterized by fluctuations between over-involvement (i.e., intrusive, hostile, and demanding comments and/or behaviours) and under-involvement (i.e., unresponsive, rejecting comments, and/or behaviours). Accordingly, interventions should be designed to address such instabilities in behaviours by either targeting the mother-child relationship or the mother’s behaviours alone. However, as previously stated, treatments designed specifically for mothers with BPD and their children, do not yet exist. Interventions that are currently recommended for mothers and family members with BPD include attachment therapies (especially during infancy and through the preschool period) and psychoeducation-based interventions. This section will compare and contrast these two treatment approaches, as they relate to the parenting behaviours and therapeutic needs of mothers with BPD. By doing so, I will argue that mothers with BPD may require psychoeducation and parent-skills training before parent-infant attachment strategies are addressed in treatment.

**Attachment-based Interventions**

Attachment-based interventions address preventing the transmission of insecure (e.g., anxious, avoidant) and/or disorganized attachment from the parent to child through either psychotherapy with the mother or with the mother-child dyad. Based on the research discussed in the previous section, disorganized attachment during infancy is an outcome for infants of mothers with BPD (Hobson et al., 2005). As a result, attachment-based treatment approaches are important to examine and discuss when considering how to improve and secure relations between a mother with BPD and her child. Interventions designed with the parent as the primary patient aim to provide ‘corrective’ attachment experiences through interactions and experiences with the therapist (Lieberman & Zeanah, 1999). For instance, during individual psychotherapy, the mother talks about her own childhood experiences and links these events to her current relationship with her child, which allows her to gain insight into how she may perpetuate the cycle of insecure and/or disorganized attachment. However, this mode of improving attachment through individual psychotherapy with the mother has not been well manualized, which has deterred dissemination, and evaluation efforts (Slade, 1999).

The second approach of attachment-based psychotherapy is to intervene at the level of the relationship between the mother and child (Stern, 1995). Like individual psychotherapy, mothers also discuss the interactions and experiences they had with their caregivers. However, the difference with this approach is that it is the therapist’s observation of the interactions between the mother and the child that facilitates the mother linking her past experiences and own attachment style to that of her current relationship with her child. There are several codified examples of this type of parent-infant relationship psychotherapy, including Watch, Wait, and Wonder (WWW; Muir, Lojkasek, & Cohen, 1999), Preschooler-Parent Psychotherapy (PPP or toddler-parent psychotherapy; Cicchetti, Rogosch, & Toth, 2000), and Circle of Security (COS; Marvin, Cooper, Hoffman, & Powell, 2002). These interventions differ with respect to the amount of psychoeducation they offer. For ex-
crease maternal sensitivity toward their infants and children, they have little impact on the attachment style of the mother or the child (van Ijzendoorn, Juffer, & Duyvesteyn, 1995). Accordingly, recent efforts have included manualizing these interventions, especially for parent-child dyads, which has resulted in greater evidence to support their effectiveness for fostering a more secure attachment style. In particular, PPP for depressed mothers (Cicchetti, Toth, & Rogosch, 1999), and maltreated children (Toth, Maughan, Manly, Spannola, & Cicchetti, 2002), and COS for disadvantaged parent-toddler or parent-preschool dyads (Marvin et al., 2002) have all demonstrated efficacy for improving attachment between mothers, and children.

As a result, even though attachment-based interventions are becoming codified and researchers are beginning to demonstrate their effectiveness in improving attachment patterns in high-risk parent-infant dyads, the utility of these interventions when offered alone for mothers with BPD and their children is questionable. There appears to be a gap between the objectives of attachment-based interventions and the goals of mothers with BPD when seeking professional help (Newman & Stevenson, 2008). That is, as previously addressed, mothers with BPD express to practitioners their difficulties with everyday parenting abilities, such as maintaining daily feeding, and sleeping schedules and routines for their infants (Newman & Stevenson, 2008). Findings from research regarding parenting practices and efficacy also underscore concerns pertaining to scheduling (Conroy, Marks, Schacht, Davies, & Moran, 2009), in addition to mothers’ distress, lack of satisfaction, and perceptions of incompetency regarding their parenting abilities (Newman et al., 2007). Accordingly, attachment-based interventions applied without a direct focus on parenting skills are unlikely to alleviate the distress and concerns mothers have about providing basic needs for their children (Newman & Stevenson, 2008). It appears that mothers with BPD may require psychoeducation and parent-skills training before addressing parent-infant attachment strategies.

Psychoeducation-based Interventions
In contrast to attachment therapies, which focus on individuals with BPD, psychoeducational approaches typically disseminate information on a variety of issues
relevant to family members and friends of the afflicted (Gearing, 2008). Given that none of these treatments have been developed specifically for mothers with BPD and their children, they will be addressed in the following paragraphs because many of the guiding principles of family psychoeducation could be relevant for parent-child interventions for mothers with BPD. For instance, these guiding principles include forming social networks with other individuals in the group (e.g., other mothers), as well as learning information about the targeted individuals (e.g., infancy and toddlerhood developmental milestones).

Family-based psychoeducation programs for individuals with serious mental illnesses have received extensive empirical support for reducing relapse rates, family stress, caregiver burden, and feelings of criticalness (Cohen et al., 2008). As such, a family psychoeducational approach to the treatment of BPD has been advocated (Gunderson, Berkowitz, & Ruiz-Sancho, 1997). More specifically, the development and benefits of the Multiple Family Group (MFG) program have been described, such that improvements in family communication and family burden are found after 6 months of this treatment program (Gunderson et al., 1997). The psychoeducational MFG approach is a social treatment that focuses on diminishing stress in the BPD patient’s family environment. While MFG does not specifically address BPD psychopathology, it is intended to create a familial ‘custom-made’ environment that will trigger the sensitivities of individuals with BPD less (Gunderson et al., 1997). As a result, Gunderson and colleagues (1997) suggested that this treatment would be appropriate when more support and structure are needed for patience, and it would help them be able to do more interpersonal work.

Currently, there are three treatments that include family psychoeducation as one component of the treatment model, which have been empirically examined for their effectiveness for families with BPD: (1) Systems Training for Emotional Predictability and Problem Solving (STEPPS; Blum, Pfohl, St. John, Monahan, & Black, 2002), (2) Family Connections (FC; Fruzzetti & Hoffman, 2004); and (3) Multigroup Family Skills Training as part of Dialectical Behaviour Therapy for adolescents (Miller, Rathus, & Linehan, 2006). The relative focus on the family members and other support persons compared to the afflicted individual varies in these treatments. More specifically, FC focuses exclusively on family psychoeducation, whereas the two other programs focus solely on the individual with BPD within their models, and include family members and other support persons in a supplementary fashion.

Overall, research supports FC to alleviate caregiver stress (Fruzzetti & Hoffman, 2004), and STEPPS along with multifamily skills training to improve patient outcomes (Blum et al., 2002; Miller et al., 2006). However, STEPPS and multifamily groups do not routinely collect information from family members or friends involved in the treatment, which limits the ability to determine their effectiveness for ongoing family and friend’s involvement in treatment. Nonetheless, these programs have implications for the development of parent-child interventions for mothers with BPD, especially if the child is also experiencing psychological problems. Accordingly, mothers with BPD may benefit from information about typical and atypical child development, as well as recommended parenting practices, and behaviours.

Strategies for Future Parent-Child Interventions

Based on the review of parenting practices, as well as the comparison of current parent-child oriented interventions, there is a strong rationale for developing a specific parent-child treatment intervention for mothers with BPD. However, there are several factors that may limit the development of such intervention. First, there is a lack of information on the relationship between BPD and parenting, because the prevalence rate of mothers with BPD is unclear. Given that this prevalence rate is unknown, the important question of why women, rather than men, are more frequently diagnosed with BPD remains largely unanswered. It is possible that there is a gender bias in the diagnosis of BPD, given that, to varying degrees, sociocultural factors (i.e., gender norms and expectations) inevitably play a role in the expression of disease conditions, and that personality disorders, including BPD, have cultural histories (Bjorklund, 2006). Second, some mothers with BPD may have suitable and effective parenting capabilities, despite their diagnosis. However, most mothers with BPD, due to the impairments and challenges specific to this affliction, may face challenges with parenting.
Another crucial therapeutic objective for mothers with BPD is to teach effective ways of adhering to routines, even during difficult circumstances. Learning about the psychological importance of routines (e.g., sleeping, eating, leisure) both for themselves and their children, as well as how to effectively start and maintain a schedule would be useful. In addition, learning how to consistently monitor and supervise their child based on their developmental stage and individualized needs would also be beneficial. Subsequently, increasing these skills—which mothers with BPD report they lack (Newman & Stevenson, 2008)—may promote parenting self-efficacy, as well as decrease the distress, dissatisfaction, and incompetence that these women may feel about their parenting capabilities (Newman et al., 2007).

With respect to emotion-related parenting practices, which are believed to play a key role in the socialization of emotion regulation in children (Morris, Silk, Steinberg, Myers, & Robinson, 2007), an important target for these mother-child dyads should be to facilitate mothers’ positive and consistent responding to their children’s displays of emotion. For example, mothers should be taught emotion-related strategies that do not involve mocking, criticizing, or punishing a child for his or her emotional expression (Eisenberg et al., 1996). It would also be important to help mothers plan how to consistently provide warmth and nurturance, regardless of moments of their own extreme emotional distress and urges to control or avoid their children’s emotional expression. For example, supportive maternal responses can assist the child in practicing strategies for managing emotions during more stressful social interactions with peers and adults.

Finally, in order to provide consistent behavioural and emotional support to their children, mothers with BPD may benefit from mindfulness-based parenting strategies. While the nature of many conflicts and disagreements that arise between parents and children are said to be habitual and repetitive, it is possible for mindfulness-based parenting strategies to help families separate themselves from such negative patterns (Du-
mas, 2005). For example, after 8 weeks of mindfulness training with parents and adolescents with externalizing disorders, adolescents reported a significant reduction in both internalizing and externalizing symptoms and parents reported an improvement in goal attainment with their child (Bögels, Hoogstad, van Dun, de Schutter, Restifo, 2005). Self-awareness might help mothers with BPD gain objectivity in difficult parenting situations, especially when their children are experiencing a strong emotion or eliciting a strong emotion in the mother. Additionally, self-awareness could help mothers with BPD learn their own limits in parenting, and when to ask for support and advice. Overall, this skill might contribute to the ability to provide a stable and warm home environment.

**Conclusion**

The effects of maternal BPD on parenting practices have been the focus of little empirical attention or treatment development efforts. The reviewed literature suggest that parenting behaviours among mothers with BPD include insensitive and dysregulated forms of communication, such as intrusive, hostile, rejecting, demanding, unresponsive, and frightening comments and behaviours. Additionally, these mothers are likely to engage in role confusion with their children, whereby their child takes on the role of a parent or friend. Moreover, inconsistent and disorganized verbal, emotional, and behavioural expressions by mothers characterize this group’s parenting behaviours. Finally, mothers with BPD are likely to have less structure in their interactions with their children and to report experiencing high levels of distress and difficulties in roles as parents, which could lead to abuse out of frustration and hopelessness. Based on these findings, developing a parenting intervention specifically for this high-risk population is an important endeavor. However, it is important for clinical practitioners to consider whether an intervention should be designed to manifest and maintain optimal mother-infant relations or to support the afflicted mothers specifically, given their fluctuations between maternal over- and under-involvement. There is a strong rationale for a specific parent-child treatment intervention for mothers with BPD, despite that accurate estimates regarding the prevalence of mothers with BPD are not known and that some mothers with BPD may have exceptional parenting capabilities. An intervention for mothers with BPD should involve psychoeducation on appropriate developmental tasks and expectations for children, consistency in scheduling and monitoring their children, positive and consistent responding to their child’s emotions, and mindfulness-based parenting strategies to enhance self-awareness.

**References**


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