Issues in Infant—Parent Psychotherapy for Mothers with Borderline Personality Disorder
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What is This?
ABSTRACT
Mothers with Borderline Personality Disorder (BPD) and their infants have been largely neglected in the research literature. This is of concern, given that clinical reports indicate that mothers with BPD have difficulties with sensitive and empathic parenting and that their children are at risk of attachment disorganization. There is little available evidence on the use of interventions with this group of parents despite clinical need. This article describes our experiences in the use of an attachment-focused psychotherapy known as Watch Wait and Wonder for improving the interaction between mothers with a BPD diagnosis and their children. A case example is provided to illustrate one mother’s response to the therapy and to highlight specific issues in clinical intervention for this group of parents and possible modifications of approach.

KEYWORDS
attachment, Borderline Personality Disorder, infant-led psychotherapy

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BORDERLINE PERSONALITY DISORDER (BPD) is a severe disturbance of personality functioning characterized by affect dysregulation, poor impulse control, identity disturbance and persistent difficulties with inter-personal functioning and attachment relationships (APA, 1994). There is considerable evidence to suggest that the development of BPD is associated with early attachment trauma (Fonagy et al., 1996). Specifically, those diagnosed with BPD are likely to have experienced mal-adaptive, abusive or neglectful parenting with subsequent impact on emotional and psychological development. Parents with histories of attachment disruption and trauma, when this is unresolved, are at risk of re-enacting or replicating these distortions of interaction with their children. Thus parents with BPD are at high risk of exposing their children to traumatic experiences that impact on their social and emotional development.

The psychological tasks of parenting, specifically the tolerance of dependency and the physical relationship with the infant, and conflicts over nurture, are particularly acute for parents with BPD and may present as either anxiety, distress or even rejection of the infant. Significantly, the infant may be identified in the mind of the parent with an unresolved traumatic attachment figure from the past of the parent establishing a pathological dynamic in the current relationship. The academic literature, however, has paid little attention to the issues faced by parents with BPD and how these issues impact on their children (Newman & Stevenson, 2005).

Few studies have examined the relationship between mothers with BPD and their infants. Interestingly in the available studies, mothers with BPD have been observed to be intrusive, insensitive and poorly attuned to their infant’s needs and communication when compared to mothers with no apparent psychopathology (Crandell, Patrick, & Hobson, 2003; Hobson, Patrick, Crandell, Garcia-Perez, & Lee, 2005; Newman, Stevenson, & Boyce, 2007). This disturbance in the mother–infant interaction is likely to result in an insecure and disorganized attachment in the child (Main & Solomon, 1990) and also perpetuate the continual development of a malfunctioning relationship. Given the likelihood of poor outcomes for the children of mothers with BPD, it is important to consider how to intervene to assist these high-risk mother–infant dyads. Over the last 3 years we have been conducting a clinical intervention programme for mothers with a diagnosis of BPD using infant–parent psychotherapy with a focus on improving parental capacity to understand the communication and internal world of their infant. This article will discuss our experiences in the implementation of Watch Wait and Wonder (Muir, Lohkasek, & Cohen, 1999), a manualized infant–parent intervention. A case study is provided to help illustrate key points.

Infant–parent psychotherapies for high-risk mothers

A central clinical and research question is whether mothers at risk of distorted interactions with their infants may benefit from early intervention approaches. There are a number of approaches that can be used to intervene with high-risk mothers and these generally fall into two categories: (1) Individual psychotherapy, which focuses on furthering the mother’s understanding of the effect of her experiences on her current functioning, and specifically her ability to form and maintain relationships and her current representation of the infant (Stevenson & Meares, 1992); and (2) infant–parent relationship-focused psychotherapy, which focuses on understanding of the recapitulation of attachment themes from the parents’ past in the current relationship with the infant and on increasing parents’ awareness of the impact of their care giving on the infant’s development (Lieberman, Silverman, & Pawl, 2000). There is ongoing
discussion as to the relative roles of individual psychotherapy for mothers with significant developmental psychopathology and infant–parent interventions. Proponents of maternal psychotherapy approaches argue that the gains of psychotherapy will generalize to the relationship with the infant. Infant–parent psychotherapists argue that interventions are needed at the level of the relationship and that infant outcomes will be improved by the use of attachment-focused approaches which may be seen as approaches emphasizing the regulation of emotional interactions between carer and infant. Furthermore, it is argued that there are likely to be more rapid gains if dyadic approaches are used. However, these issues are yet to be examined empirically.

One example of an attachment-focused approach is that developed by Muir et al. (1999) known as Watch Wait and Wonder (WWW). The intervention requires the mother to focus on the infant’s bids for communication. It aims to improve dyadic interaction and promote security of attachment by promoting maternal capacity to observe and reflect on the meaning of the infants’ behaviour and emotional communication. The authors describe this as an ‘infant-led’ approach as it aims to provide the infant with an experience of self-agency and to develop the mothers’ capacity to see her infant as psychologically independent and actively communicating. Theoretically, this approach may be seen as improving parental sensitivity and reflective capacity (Slade, 2005). Reflective functioning or mentalization refers to the capacity to understand one’s own and others’ behaviour in terms of mental states and intentions (Fonagy et al., 1995; Fonagy, Steele, Moran, Steele, & Higgitt, 1991) and is theorized to be the underpinning of self-regulation and relatedness. Infant–parent therapies focus on supporting parents in reflecting on the infants’ internal experiences, needs and motivations which should promote the development of attachment security and emotional regulation. Limited outcome studies support the view that this focus in infant–parent intervention promotes attachment organization (Cohen et al., 1999).

The WWW approach involves a therapy room with standard toys (e.g. doll, tea set, wild and domestic animal farm set, doctor’s kit, soft toys). Each session begins with the parent being asked to ‘get down on the floor’ and observe and follow their child’s lead in activities. During the first half of the therapy session, the therapist sits in the room but does not interact with the dyad. The second half of the session involves a discussion between the parent and therapist about the activities initiated by the child and the parental understanding of their child’s behaviour and play. Although preliminary research into the efficacy of WWW for high-risk mothers is encouraging (Cohen et al., 1999; Cohen, Lojkasek, Muir, Muir, & Parker, 2002), this intervention has not been specifically developed for mothers with BPD. As part of a larger research project examining parenting issues for mothers with BPD (Newman et al., 2007) we offered a WWW intervention programme which is described later.

**Watch Wait and Wonder (WWW) for mothers with BPD**

The authors have recruited approximately 20 mothers with BPD into a study into the nature of transgenerational attachment in mothers with BPD and their children. Six mothers from this original study, agreed to participate in WWW. We acknowledge that our sample size is small, however, it is important to remember that mothers with BPD have difficulties in attending appointments and committing to a therapeutic relationship. Mothers were asked to attend 12 to 14 WWW therapy sessions with their child, over a period of 5 months. The therapists were final-year students of the Master of Infant Mental Health course conducted at the New South Wales Institute of Psychiatry, Sydney, Australia. The therapists received weekly supervision by the first author. A case example
is provided to illustrate the WWW process and to increase awareness of the types of issues raised during therapy.

As part of the broader research all mothers were formally assessed and met DSM-IV diagnostic criteria for BPD and scored > 8 on the Revised Diagnostic Interview for Borderlines, a semistructured interview that reliably distinguishes BPD from other personality disorders (Zanarini, Gunderson, Frankenburg, & Chauncey, 1989).

Clinical case example

Background
Faye was a 35-year-old woman who had conceived Elizabeth following a casual affair. Faye’s early childhood was characterized by severe emotional, sexual and physical abuse. During her childhood and adolescence, she was placed in multiple group homes and foster families and had no experience of consistent and sensitive parenting. She remained preoccupied with her past trauma and had some features of PTSD. She met diagnostic criteria for BPD. Faye’s personal history was characterized by ongoing difficulties in regulating her affective states and in tolerating negative affect. She had major difficulties in sustaining reciprocal relationships and felt chronically at risk of rejection and abandonment. She had made several suicide attempts, engaged in self-harming behaviour and promiscuous sexual activity. Faye had been hospitalized for depression and suicidal behaviour on numerous occasions. Faye had received intensive individual psychotherapy on a twice-weekly basis for 2 years when she was 30 years of age and attended a group, Dialectic Behavior Therapy Program, for 6 months a year before attending the current programme. She described some improvement in her impulsivity and reduced self-harm after this but still felt she had difficulties in her relationship with her child and in seeing herself as a parent.

Pregnancy and delivery
Fay reported hospitalizations during pregnancy due to suicidal thoughts and had contemplated termination of the pregnancy on numerous occasions. She described a lack of connection with her developing infant and remained highly ambivalent about the prospect of parenthood. She had been pregnant twice before and these pregnancies were terminated. She became increasingly depressed and suicidal as the pregnancy progressed and was hospitalized at 5 months gestation up to the onset of labour. Faye described her labour as long, painful and stressful, requiring instrumental delivery. After the birth, Faye and Elizabeth were transferred to a specialist mother and baby unit for further assistance. Within weeks, Faye was diagnosed with Postnatal Depression. She remained depressed for several months and experienced Elizabeth as demanding and intrusive. Faye felt herself to be overwhelmed by the demands of parenting and took little pleasure in the relationship. She saw herself as a ‘bad’ mother and worried that she would repeat her own mother’s rejection and abandonment of her with Elizabeth. Faye was able to breastfeed her infant but was never able to engage in mutual gaze. Faye ‘forced’ herself to spend time with Elizabeth and worked hard to project an image of herself as an ‘engaged’ parent. Internally however, she felt empty and depleted and angry at the neediness of her child.

Child’s clinical status
On presentation to the current programme, aged 2 years, Elizabeth appeared to be a very independent, intelligent and precocious child. She needed to be the centre of attention and would sing and entertain the clinic staff. Her behaviour was socially
indiscriminate. In the Strange Situation Procedure (SSP), Elizabeth’s behaviour appeared avoidant and disorganized – that is, she consistently attempted to distance herself from her mother and showed features of conflict and dissociation around contact with her. She distracted herself with toys rather than seeking contact and comfort from her mother. When Faye and Elizabeth were asked to play for 10 minutes as they usually would at home, the play appeared stilted and unnatural. Faye preferred to ‘teach’ Elizabeth and interacted with her in a controlled and controlling fashion with little positive affect.

**Diagnostic formulation**

On the SSP, Elizabeth presented with an insecure avoidant and disorganized attachment style and was at high risk of developing an attachment disorder (Newman & Mares, 2007). Child protection services were supervising the case and arranged for Elizabeth to attend day care 5 days a week and spend alternate weekends in respite care. Faye’s history of severe abuse and neglect appeared to be influencing her perception of Elizabeth and was negatively impacting on her capacity to tolerate her daughter’s dependency and attachment needs. Faye was rejecting of Elizabeth but at the same time saw her as ‘not needing’ a mother and felt rejected by Elizabeth. Faye viewed Elizabeth’s behavior as ‘very advanced’ and justified this by saying that ‘she did not cry on separation like the other children’.

Faye had a good intellectual understanding of BPD and her own difficulties with affective regulation, and attributed this to her participation in the DBT course. Interestingly, she also stated that the DBT program had not helped her manage specific difficult feelings in her relationship with Elizabeth. She agreed to participate in WWW and to attend 12 to 14 sessions of therapy. Faye was particularly interested in what she perceived as ‘Elizabeth’s avoidance of her’ and whether this constituted a ‘mental disorder’. Faye herself described that she felt ‘comforted’ by her own diagnosis of BPD as it provided some sort of explanatory framework for her emotional distress.

Faye presented as intellectualizing and emotionally avoidant. She found Elizabeth’s emotional demands incomprehensible and overwhelming. She frequently attempted to discuss theories of child development and was familiar with the vocabulary of psychotherapy. WWW seemed an appropriate intervention as difficulties were observed in the mother–infant interaction and specifically in Faye’s capacity to acknowledge Elizabeth’s emotional needs. In addition, WWW had the advantage of containing Faye’s anxiety and supporting her in observation of Elizabeth and reflection on the meaning of her behaviour.

**Treatment**

The first three to four sessions were characterized by a settling in period. Faye continually wanted feedback and asked, ‘am I doing this right?’, ‘what am I supposed to be doing?’. She was anxious and distressed. This was expressed together with a sense of despair characterized by statements such as ‘this is the most boring thing I have ever done!’ Faye requested that she bring her own activities from home, as she and Elizabeth preferred to engage in craft activities rather than ‘playing together’. In Session 3, Faye bought play dough from home and was determined to play with the dough. She had to be gently encouraged down to the floor to watch Elizabeth. A theme that crossed these initial sessions was Faye’s persistent seeking of solutions for day-to-day parenting issues, such as her concern over how Elizabeth reacted to a loud noise. She wondered if Elizabeth had an ‘anxiety disorder’ or was herself developing a personality disorder. She seemed guilty and distracted by the thoughts of her child’s future and determined to find
practical solutions rather than reflect on the meaning of her anxieties. The therapist had to constantly remind Faye of the instructions for WWW and encourage her to allow Elizabeth to lead the play and then to be curious about how her daughter was making sense out of things in her life. It was interesting to observe that as Faye became distressed by the WWW process, she experienced an increasing number of physical complaints—her knees became sore so she could not get down to the floor and then she missed a number of sessions due to a pain in her back and shoulders.

The middle sessions were characterized by Elizabeth spending the majority of her ‘play’ time caring and looking after toys and animals in the room. For example in Session 6, she spent her time putting toys to bed, giving the toys bottles, a dummy each and kisses. Elizabeth tried to encourage her mother to join in the activity. Faye was only able to roll her eyes as if to say, ‘what is she doing now?’. She appeared hostile and rejecting of Elizabeth’s clear communications about comfort and nurture. While Elizabeth acted out her need to be nurtured, Faye wanted to discuss her own difficulties with interpersonal relationships. Faye was not able to interpret or reflect on the caretaking behaviour despite its being a dominant theme in Elizabeth’s play across all the middle sessions.

During the final sessions, Faye appeared to become more comfortable with the experiential nature of the therapy and to have gained greater understanding of Elizabeth’s anxieties and her own role in making Elizabeth insecure. She began to report enjoying play and contact with Elizabeth and described sending visitors home so that she could spend more time with her daughter. She acknowledged that Elizabeth needed to be with her and her own difficulty with this. She also could articulate the dilemma of finding the ‘correct’ distance to be with her child. Concurrently we noticed that Elizabeth was less preoccupied in her play with themes of care and nurture and was better able to engage with a variety of activities. She appeared less anxious and Faye was able to join in her play. Overall our clinical impression was that Faye was more empathic in her interactions with Elizabeth and that, as a result, the child’s experiences and communications were validated.

At the end of the therapy, Faye agreed to be interviewed about her thoughts and feelings relating to the therapy. It was interesting that the main theme of this interview was about her need for models or examples so that she could ‘copy’ how to interact with her daughter. Interestingly, Faye thought it would be helpful to have videotaped examples of ‘good’ interactive styles acknowledging the need for support in ‘watching’ and reflecting on her interaction with her child. Working with videotaped sequences of infant–parent interaction is part of clinical intervention such as Video Interaction Guidance (McDonough, 2004) and could usefully be explored in parents with BPD who describe ongoing difficulties in their interaction with their child (Newman, 2005).

Reflections on WWW as an intervention for mothers with BPD

In this section, observations that the authors have made over the course of introducing WWW to mothers with BPD are discussed. These include: (1) the mother’s surprise at the nature of the intervention, (2) meeting the families basic needs for routine and structure, (3) mother’s tolerance for interaction with their child, (4) maternal resentment for the attention their child was receiving, (5) re-enactment of past trauma, (6) child’s need to engage the therapist, (7) the reflective functioning of the mothers. Each of these issues is discussed together with practical ways in which we altered the intervention to meet the needs of the client group.
The nature of the intervention
WWW was explained to each mother as an intervention aimed at improving their relationship with their child. They were specifically told it was not therapy for them and it was not therapy for their child. The purpose was to improve their interaction. Despite the fact that the aim of therapy was very clearly stated, mothers had to be repeatedly reminded to bring their infant with them. Thus, the first issue that we faced was how to effectively engage mothers with BPD in this intervention.

The concept of a therapy for the relationship posed novel and challenging. It was not uncommon for mothers to want to talk exclusively about their own concerns rather than engage in any activity with their child. The therapy appeared to produce envy and competition with the child, by the mother, for the attention of the therapist. Thus, it was important to ensure that mother felt ‘heard’ rather than neglected by the focus on the relationship. It was felt that unless the mother had a space to talk about herself and her concerns, she would not return for subsequent sessions. One attempt we made to overcome this problem was to have a ‘special time’ for the mother, at the end of each session, during which time the child was looked after in another room. This adaptation proved to be effective for a number of the mothers. It provided a space where mothers could talk about parenting concerns such as sleep, settling, feeding etc. and about personal concerns. The aim in introducing this component to the therapy was to keep ‘nonrelational’ issues separate from the therapy. This extra time, usually lasting about 20 minutes, was used solely to listen to the mother’s concerns rather than offer any solutions.

At times attendance at therapy was erratic, often due to the mother’s disorganization and chaotic interpersonal experiences. Thus from the outset we were aware that weekly sessions would probably be impractical and that it would be better to achieve a set number of sessions within a given time period – hence we aimed for 12–14 sessions within a 5-month period. Generally this was a successful approach and did not produce any problems with continuity.

The inability of mothers to meet their child’s basic needs
As was the case with Faye, it was not uncommon for mothers to have difficulties in the practical day-to-day tasks of parenting. Therapists noted that a number of mothers were not able to maintain simple routines with their children, for example feeding at set times or regular bedtimes. This caused concern with some therapists experiencing a desire to teach appropriate strategies for overcoming child-management issues rather than engage in WWW. This issue was debated within the supervision group and this enabled us to refocus on our primary aim of improving the interaction between mother and child. However, it cannot be understated how difficult it was to adhere to the WWW protocol in the face of the overwhelming issues that the mothers with BPD presented with. Our rationale for adhering to the WWW protocol was that any improvement that we were able to facilitate in the interaction between the dyad could have long-term benefits for the child. It was also clear that maintaining child safety and adequacy of care needed to be prioritized.

Maternal tolerance for interaction with their child
Another observation the authors have made about mothers with BPD is that some mothers have a very low tolerance for being present with their children. Mothers either stated their boredom or showed evidence of this by yawning and looking around the room. It seemed that the mothers’ own experiences of poor and neglectful parenting were active and unresolved, and as a consequence these mothers had difficulty tolerating the
intimacy involved with the therapy and had a core deficit in their representation of the infant. This is illustrated in the case study, where Faye repeatedly stated, ‘what am I supposed to do?’ and ‘this is the most boring thing I have ever had to do’, indicating that intimate interaction in a play situation was unusual and anxiety provoking. Our approach was to offer gentle encouragement to stay ‘on task’ and, by doing this, increase the mother’s tolerance to interacting with their child and begin the process of watching and thinking about the child.

**Maternal resentment for the attention their child received**

Some mothers expressed their resentment towards playing with their child and were even able to articulate their distress that ‘no one did this for me’. This envy was an issue that needed to be carefully managed. Some parents needed to be nurtured and supported by the therapist as they came to acknowledge the neglectful parenting that they had received. In addition, it was important to promote the concept of the parent’s ability to make things different for their child and to work with parents to develop a positive representation of their own capacity to parent. In addressing this issue, it was important that therapists were mindful of meeting and balancing the needs of both infant and parent.

**Re-enactment of past trauma**

Occasionally, evidence of past trauma was observed being re-enacted in the interaction between mother and child. On occasions, mothers ignored behaviour that might have caused their child harm, such as when a child stood up on a stool that was about to fall over. On other occasions we observed mothers having difficulties managing unacceptable behaviour and being threatening in their approach to managing the situation. It was of concern that this behaviour emerged in what was a very closely monitored situation and we were very aware of our child protection responsibilities. Our general approach to managing these issues was to focus the mother’s attention on the issue in the discussion half of the session, with questions such as ‘I wonder what was happening when X occurred?’, the aim being to improve the mother’s ability to relate to their child’s internal state.

Furthermore, it was not uncommon for mothers with BPD to attempt to relinquish parenting responsibility to the therapist. One mother talked about her dislike for her baby and wanted to give the baby to the therapist at the beginning of each session. This mother was encouraged to hold her baby herself. However, she subsequently dropped out of therapy, decided to return to work and engaged a nanny to look after her infant, perhaps confirming our concern that the therapy context was anxiety provoking.

**Child’s need to engage the therapist**

Many of the infants showed a strong preference for interaction with the therapist and other staff at the clinic over and above that of their mother (an indiscriminate attachment). In a number of the therapy sessions, we observed infants working very hard to engage the therapist (who was observing) in activities and conversation. This indicated to us the hunger these children had to be nurtured. When infants did attempt to interact with the therapist, therapists were encouraged to sit further away from the dyad and direct the infant’s attention to their mother by glancing in her direction. The therapists frequently experienced frustration at the mothers’ seeming incapacity to respond to the infants. Most therapists needed support in focusing on containing the mother’s anxiety and tolerating the mother’s ambivalence. This was achieved by ensuring all therapists attended a weekly supervision session.
The reflective functioning of mothers

Another issue that was raised not infrequently, in our supervision sessions, was the limited capacity for self-reflection demonstrated by the mothers. We discussed the utility of an approach such as WWW for mothers who were unable to reflect on either their child’s behaviour or their own. In the case example, Elizabeth demonstrated compulsive caretaking. In almost every session a pattern of play developed in which she would pick up and feed the dolls and care for them. Clearly, she was indicating her own needs for care and nurture. Interestingly, her mother was never able to reflect on the meaning of this behaviour. Another child used the wild animals and repeatedly acted out a situation where her mother had to have the ‘good’ animals and the child had the ‘bad’ animals. Her mother was never allowed the bad animals. In this way the child attempted to maintain an idealized and uncontaminated ‘good’ mother but at the cost of experiencing the self as ‘all bad’. Despite the persistence of this theme in the child’s play the mother had ongoing difficulty in appreciating the child’s dilemma.

The importance of clinical supervision

The WWW programme described here included a weekly supervision group, conducted by the first author. This supervision provided an opportunity to discuss issues involved in working with ‘high-risk’ dyads including the need for ongoing risk assessment and maintenance of a child protection focus. Particularly for clinicians more recently involved in this area, there is a need to reflect on therapist responses to parents struggling to maintain positive interactions with their infants and the intrusion of negative affect in the interaction. Balancing attention and involvement with both parent and infant and maintaining a dual focus is also a significant technical issue in the style of the intervention. For mothers with a history of deprivation and abuse, the positive regard and containment of the therapist supports their emerging capacity to reflect on their own affective states and the inner world of the infant. In this sense the therapist encourages parental reflective capacity and supports the development of infant autonomy.

Conclusion

Our experience with WWW has led us to the belief that additional issues need to be considered when implementing this type of intervention with high-risk mothers, such as those with BPD. First, therapists must be aware of the complex issues that traumatized parents bring to therapy. Second, therapists must contain maternal anxiety and distress and ensure mothers do not feel dismissed. Third, it is very important to adhere to the goal of therapy, that is, that of supporting parents in developing their capacity to reflect on the inner world of the child and thus to promote self-organization and security. To conclude, interventions focused on infant–parent interactions may play a role in improving the relationship of mothers with BPD and their children and should be the focus of further research attention.

References


