Understanding Personality Disorders and the impact on Mothering

Personality disorder (PD) is a recognised medical condition. People with PD;

- Experience distress and discomfort with their self-experience, especially in relation to mood and arousal
- Struggle with close relationships; especially relationships that involve need and dependency

There are different clusters of PD;

1. **Cluster A** is a socially avoidant group, who also struggle with reality testing. This group may not often come to the attention of mental health services because they are avoidant.
2. **Cluster B** is the group that draws most professional attention because people with this kind of PD experience high levels of subjective distress and also get into highly conflicted relationships with others; especially partners, caregivers and family members.
3. **Cluster C** is an anxious group, who also avoid relationships with others because of high levels of obsessional anxiety and associated depression.

A key feature of EUPD is oscillation of mood and arousal, often accompanied by suicidal ideation. People often have periods of crisis where they attempt to self-medicate with alcohol or drugs; or regulate their distress by self-harming or taking overdoses. People with PD often make very intense attachments to caregivers and easily feel abandoned if those carers are not always available. People with EUPD are often high users of mental health services and therapy.

PD develops in childhood and usually manifests in late childhood or adolescence. Studies suggest that there are degrees of severity of PD. Many people have mild degrees of personality dysfunction which may get worse under stress. Only a minority (1%) of the population have severe disorders of personality. This group are at increased risk of problematic behaviours like repeated self-harm and/or occasional violence to others. They may struggle with co-morbid problems like depression, substance misuse and brief periods of psychosis.

PD can be caused by multiple factors, including genetic vulnerability and/or adverse childhood experience. In relation to childhood adversity, the riskiest experiences are parental neglect and maltreatment. Mediating mechanisms are likely to involve unresolved distress, impairment of explicit memory and insecure attachment.

People with Cluster B disorders struggle with both care giving and eliciting relationships which generate strong and painful feelings, often associated with childhood trauma. They are at increased risk of becoming perpetrators of domestic violence and child maltreatment.

People with PD often have insecure attachment systems and struggle to manage distress effectively, trust others or express negative feelings effectively. They often express distress physically via self-harm, eating disorders or getting into angry conflicts with others.

Therapies are available that can help people with PD improve their experience and relationships; however people with PD struggle to engage in therapy initially. Professionals working with people with PD may find themselves acting out conflicted relationships with patients and for this reason clinical supervision is strongly advised. Effective communication is essential in multi-agency working as people with PD can present very differently to different practitioners which can split professional opinion.

Mothering and PD

It can be difficult for parents with PD to get therapeutic help that addresses the impact on their parenting, as adult mental health services often do not think about how mental disorders might affect parenting. The Royal College of Psychiatrists report on parental mental disorder recommended that mental health professionals develop more awareness and attention to the needs of dependent children when they assess and treat adults who are also parents to read the report click here

Greenwich perinatal mental health team provide support to pregnant women with PD and other mental health issues. Because of their attachment difficulties, women with PD often struggle with parenting babies and the emotional intensity that is involved in caring for them. Babies generate high levels of emotion in their parents, and mothers with PD may struggle with complex emotions during pregnancy and early childhood.

Women with PD are more likely to have complex pregnancies and labours and are at increased risk of anxiety and depression after birth. This emotional turbulence may make it difficult to recognise and meet children's needs. Mothers with PD can be highly ambivalent about pregnancy and parenthood. They may experience intense attachment to their babies, but also fear their distress and neediness. Some mothers with PD develop unusual concerns in relation to their babies, seeing them as sick when they are not. In some cases this begins during pregnancy.

Mothers with PD are over represented among mothers who maltreat their children. Reviews of maltreatment cases and serious case reviews find that the prevalence of PD in maltreatment perpetrators is much greater than the general population. This may arise because mothers with PD often experience hostility towards their children and find it hard to trust professionals who might be able to help them. Mothers with PD may find it especially hard to care for children with additional vulnerabilities, which may explain why children who are born prematurely or who have any physical disability are more likely to be maltreated.