Guidance to Support Staff Working with Parents with Emotionally Unstable Personality Disorder

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<th>Version</th>
<th>Issue Date</th>
<th>Review Date</th>
<th>Lead Author</th>
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<td>1.0</td>
<td>20/01/2020</td>
<td>20/01/2022</td>
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Perinatal Mental Illness

Perinatal mental illness is an umbrella term for a range of mental health problems that can occur during pregnancy or the post-partum period. These include anxiety disorders, including post-traumatic stress disorder (PTSD), depression, bipolar affective disorder, postnatal psychotic disorders and emotionally unstable personality disorder EUPD. Likewise, many women who become pregnant have a history of or are already experiencing mental health or psychological difficulties, which can become exacerbated at this point in a woman's life. This is due to the multiple environmental and hormonal changes, life stressors and role transitions that can occur.

This guidance specifically focusses on EUPD, a chronic condition which affects many women and has the potential to be quite challenging for a woman as she becomes a mother.

Emotionally Unstable Personality Disorder (EUPD)

What is Emotionally Unstable Personality Disorder (EUPD)?

Emotional Unstable Personality Disorder (EUPD), also known as Borderline Personality disorder (BPD) or Complex PTSD, is characterised by a pattern of instability in relationships, mood, and impulsivity. There is no single cause identified for EUPD, but as with most mental health problems, it’s causes are multiple and include both genetic (nature) and environmental (nurture) factors. There is substantial comorbidity of EUPD with common mental disorders, such as depressive illness, the range of anxiety disorders, substance misuse disorders, other personality disorders, and eating disorders. (NICE, 2017)

Estimates of the prevalence of EUPD vary between 0.7 and 2% in the general population. 75% of those diagnosed with EUPD are female, but it is likely that it is underdiagnosed in males, as women are more likely to seek help for the disorder.
Symptoms of EUPD

EUPD can be a disabling condition and often takes a huge toll on the individual and the people around them. People with EUPD usually develop signs and symptoms of the disorder in adolescence or early adulthood, whilst their personalities are forming. This is one reason why the diagnosis should not be made before the age of 18. Symptoms vary between individuals and over time, but they may experience difficulties in the following areas:

- intense, highly changeable moods that can last several days or rapidly cycle within hours. This can be difficult to distinguish from bipolar spectrum disorder. These moods include anxiety, irritability, depression, excitability and elevated levels of distress
- dysfunctional self-image or a distorted sense of self (how one feels about one's self)
- feelings of isolation, boredom and emptiness
- lack of self-confidence
- impulsivity
- risky, self-destructive behaviours including reckless driving; drug or alcohol abuse and sexual promiscuity
- excessive sensitivity, mistrust and hostility in relationships
- persistent fear of rejection, abandonment and criticism including extreme emotional reactions to real and perceived abandonment
- difficulty understanding the point of view of others
- craving closeness, but intense and unstable emotional responses which tend to alienate others, causing long-term feelings of isolation. They often have a history of unstable relationships which can change drastically from intense love and idealisation, to intense hate
- self-harming behaviour, e.g. cutting; burning; head banging; overdosing and other methods of causing intentional self-harm
- suicidality (thoughts of intentionally ending one’s life)
Impact of symptoms of EUPD

As a consequence of the above, it can be difficult for people with EUPD to develop mature and lasting relationships, or to function effectively at home, in educational settings and in the workplace. Failures in these areas accentuate feelings of rejection, depressive moods and self-destructive impulses. As a result of their difficulty in controlling their impulses and emotions, and also their often distorted perceptions of themselves and others, people with EUPD may experience enormous emotional pain and evoke high levels of anxiety in those around them, without truly understanding the impact they are having on others.

Their risky behaviours can also induce anxiety in professionals working with them, which again can further impact their sense of feeling misunderstood by others and give rise to beliefs that they are unable to be cared for. People with EUPD tend to make frequent contact with mental health services, social services, accident and emergency departments, GPs, and the criminal justice system. These systems can often struggle to meet their needs, sometimes inadvertently replicating early experiences of invalidation and rejection.

Suicide, Self-Harm and EUPD

Suicide

Suicide is particular risk in people with EUPD, with up to one in 10 people with EUPD ending their own lives. It’s likely that some of these deaths are a result of accidental self-harm. Suicidal thoughts are prevalent for people with this condition. During the perinatal period, mothers with EUPD are more likely to find the demands of parenting more emotionally demanding, and alongside hormonal changes that occur during the perinatal period, may have an increased propensity towards suicidality and/or intent to end their life. Risk assessment of suicidality during the perinatal period is qualitatively different to risk outside of this time, and women who have suicidal thoughts are more likely to act on them if they are in the perinatal period. Women are more likely to die from violent methods of suicide in the perinatal period than at
other times of their life, and thoughts of violent self-harm are a red flag risk factor. Clinicians working with women who present with risk factors during the perinatal period, are advised to consult with a perinatal mental health specialist.

Self-Harm

Repeated self-harm can be conceptualised as a method people use in an attempt to regulate painful emotions. Whilst self-harm or thoughts of suicide can often offer an immediate reduction in distress, for most people this only works in the short-term, and many people find themselves feeling guilty and ashamed for self-harming or for having suicidal thoughts, creating additional negative feelings and self-critical thoughts, which serve to increase and compound the original source of distress. In the absence of alternative coping methods, people with EUPD are then again more likely to use self-harm and suicidality to cope, also meaning they are at increased risk of self-harm and suicide in the future.

In order to avoid contributing further a person’s pain, clinicians can play an important role in exploring a person’s difficulties using a compassionate and non-judgemental approach. It can be helpful to think together with the person about the function that self-harm and suicidality might have for the person, and to collaboratively consider the effectiveness of these strategies in the short and long-term. It is also useful to discuss how these particular coping strategies are, or are not in line with the person’s values and what’s important to them.

Causes of EUPD

Whilst there are no clear causalities of the development of EUPD, current research points to its development to be due to an interaction between biological factors (such as genetics/ hormonal sensitivities) and environmental factors (such as an early invalidating environment, a history of abuse, early attachment difficulties with caregiver).

There is often a history of traumatic events during childhood and adolescence, in particular physical, sexual and emotional abuse; neglect; witnessing hostile conflict
or early parental losses or separations (with either physical or emotional absence). People who develop EUPD may have parents who have EUPD or other mental health difficulties, and there can therefore be a transgenerational effect of the disorder.

Increasingly, due the high prevalence in early and ongoing trauma in the lives of patients who have EUPD, it is being reconceptualised as a diagnosis of Complex post-traumatic stress disorder (PTSD). This is a less stigmatising diagnosis reflecting its causes rather than conceptualising the pattern of symptoms and behaviours as a flawed personality.

The Impact of EUPD on Parenting

Parental mental health problems can have an impact on the entire family, including children and significant others. Not all parents who have EUPD or other mental health difficulties will have symptoms severe enough to require being under mental health services, but they are likely to have contact with GPs, antenatal services and health visiting and they may have contact with Children’s services. It is important for professionals working with parents experiencing parental mental health difficulties to collaborate across professional boundaries to support them collectively, to manage their condition and minimise the impact of their health on their children. The chronic and enduring nature of the condition can pervade all aspects of the person’s life and takes time to treat.

It is important to stress that a diagnosis of EUPD does not automatically mean that a parent will struggle with parenting their child. Many individuals with EUPD become nurturing, responsive and loving parents. They have good insight into their own psychological challenges and becoming a parent can be an incentive and a change in their life that promotes insight, awareness and a determination to change their lives for the good. However professionals need to be aware of the vulnerability that these individuals have.

Professionals working with parents experiencing EUPD should be aware of the following potential impacts of the condition on their parenting:
• The individual may have had a poor experience of being parented themselves and so do not have a healthy template to follow about how to be a more effective parent. This may negatively impact the attachment they develop with their baby.

• If the parent has idealised the concept of becoming a parent to in some way to repair the damage they experienced themselves as a child, or to make them feel loved / needed, this can mean they confuse their own needs with their child’s and the child is put in the position of looking after their parent’s wellbeing.

• The parent-infant relationship is a new relationship in the individual’s life and like other relationships, the parent may find this relationship very intense, and may experience it at times as one of rejection and hostility, for example when the baby cries for prolonged periods of time. This may impact the parent’s capacity to appropriately soothe their baby.

• Prolonged crying in the baby may evoke overwhelming feelings in the parent of anxiety, anger, hostility or helplessness. If the parent is isolated, without appropriate support from a partner, family or friends, the baby may be exposed to these feelings and in extreme situations may be at risk of physical harm.

• As the baby/child gets older the parent may struggle to set and stick to boundaries that evoke anger or distress in their child as they worry that their child will no longer love them if they do.

• As the baby/child begins to develop independence this may be experienced as a rejection or that the parent no longer feels needed by the child. The parent may respond to this by inadvertently undermining the child’s steps towards independence or withdrawing from the child or alternating between these 2 positions. This can lead to the child feeling insecure, being needy and staying in an intense relationship with the parent.

• The parent may have difficulty separating their own needs from the child’s and fully understanding things from the child’s perspective. This may mean that they have difficulty understanding their child’s needs and responding to them sensitively.
• The parent may have a low threshold for tolerating distress and the intensity of looking after a young child can exacerbate this and lead to further strain on their mental health, especially after a build-up of time. If they have difficulty controlling emotions around their child, e.g. showing intense anger or rapid or extreme mood swings, this can confuse or frighten children. If a parent feels overwhelmed with their own emotions they may be emotionally unavailable to their child and may struggle to help their child to learn to manage intense emotions in a healthy way.

• Due to the nature of EUPD and how it negatively affects a person’s ability to foster relationships, there may be limited informal support available to the mother. She may not have access to a support network or positive relationships.

• Some parents with EUPD may continue to engage in risky and / or impulsive behaviour which puts them or their child at risk.

• If the parent is feeling very low, apathetic and withdrawn, they may neglect their own and their child ‘s needs, for example, maintaining routines around bedtimes, mealtimes, meeting physical needs around food, personal hygiene, making and attending appointments or appropriately supervising their children and keeping them safe.

**Impact on the Infant**

Parenting styles which offer a child a sense of safety, warmth and clear boundaries are known to play a crucial role in the development of a healthy and secure attachment. Pregnancy and the months after delivery can evoke strong feelings of attachment anxiety in the mother as she may begin to remember any traumatic attachments from her own childhood. Babies require consistency and have needs and demands at this stage that a mother with EUPD may find overwhelming.

This can be significantly more impactful during a child’s first year of life, as well as in utero, given research from epigenetic studies which show how increased distress in a mother can negatively impact a child’s neural pathways. Naturally, severe and
enduring mental health difficulties are likely to correlate with increased negative outcomes for the child.

Babies and young children of parents with mental health problems can be at increased risk of the following:-

- Prematurity/with a low birth weight
- Development of behavioural problems such as physical aggression by the time they reach school age.
- Developing mental health difficulties at an early age
- Sleep problems and irritability
- Unhealthy (e.g. insecure / disorganised) attachment
- Have delayed intellectual, emotional, social and psychological development

**Impact on the Child and Young Person**

Parental mental health problems can have an impact on child health and wellbeing in various ways and these include:

- Role reversal – children can take on the caring role for their parents and other family members (such as siblings and grandparents), providing emotional and social support, undertaking activities such as house-hold chores, nursing and personal hygiene.
- Children may prioritise the needs and feelings of their family over their own, in place of their own needs and feelings, impacting for example on play and school work.
- Children may experience childhood anxiety, as they worry constantly about their parents or caregiver’s health, wellbeing and safety
- Children are unlikely to cope with the emotional distress that results from traumatic experiences or emotional crises. For example, a parent attempting to take their own life, parent(s) displaying extremely violent and volatile behaviour, or witnessing a caregiver being sectioned under Mental Health Act and admitted in a secure hospital setting.
- Children, particularly older children and adolescents, may experience shame and social stigma in relation to their parent’s mental health. They may be
victim to bullying (including cyber bullying) which may limit their social interactions and opportunities to form supportive friendships. For young people, a key developmental need is to achieve acceptance from their peers. When this milestone is compromised it can have a significant impact on their emotional wellbeing, forming personality and core beliefs about themselves. Children may be separated from their parents in situations of risk, where the safety of the parent or others is at risk. This may mean children are taken into care or are looked after by friends/family. Such separations can leave the child with feelings of abandonment, anger and anxiety, as well as a whole host of other complicated feelings. Children may also blame themselves for the caregiver’s emotional breakdown.

- Children may have an unstable family group e.g. if a parent has multiple or changing partners. This level of change may compromise a child’s experience of a safe and reliant home base.
- There is a risk of an unhealthy attachment in the parent-infant relationship
- The parent may struggle to help the child to identify and manage emotional distress, meaning the child is also unable to do this for themselves. Children with this background may exhibit challenging behaviours and/or engage in unhealthy coping strategies, such as drugs and alcohol.

**Child Mental Health**

It is well documented that children whose parents have mental health problems can experience anxiety and frustration. Research also shows children experience a number of fears and challenges such as:-

- Fear of developing their parent’s condition themselves
- Losing the closeness they had enjoyed with their parent before their mental health problems began
- Role reversal at home, as expected to grow up and take on ‘adult/parental’ role but still treated as a child in school
- Facing contradictory expectations from their parents or carers
- Fear of being blamed for making their parents ill, or failing to protect them
• Shame and stigma projected on the family by their networks
• Social isolation, fear of being bullied or singled out by peers and other adults
• Deep concerns that their parents might never recover or that their conditions may get worse
• Worrying that the family will be split up and/or that they will be taken into care

Impact on the Professional and Services

Clients with EUPD can struggle to hold a flexible and understanding attitude towards others. They may adopt a ‘black and white’ thinking style (e.g. others are all good or others are all bad) which is one way in which they are able to protect themselves from the vulnerable feelings that can emerge when we feel let down by others. This can make clients with EUPD prone to a subconscious process, called “splitting”. In teams and services, this may be observed, for example, by the client idealising one professional/service and denigrating the other. This can lead to conflict amongst professionals and a lack of a coherent, consistent and collaborative approach for the client.

Services are also at risk of adopting an ‘enmeshed working style’ with this client group. This may mean professionals become over-involved, attempt to ‘rescue’ and so solve problems for the clients, staff go beyond boundaries and/or align themselves against workers/services. Such styles of working can inadvertently reinforce helplessness and distress in clients and encourages dependency/inhibits autonomy and responsibility.

In contrast, staff may adopt a withholding working style, which may mean practitioners assume a punitive approach, and are perhaps condescending, sarcastic or hostile in their responses to a client’s distress/ways of asking for help. This style may lead to the professional or service becoming withdrawn and reinforces an invalidating environment. It also may result in the client escalating their unhelpful behaviours in an attempt to get help (e.g. self-harm, suicide attempts, aggression).

For clients with EUPD in particular, professionals are encouraged to maintain a nurturing approach, where they can offer validating, containing and compassionate
responses. Alongside this, staff are urged to offer clear and consistent boundaries. A combination of the above is likely to leave the client feeling understood, enhancing their existing strengths and sense of being able to cope; and the provisions of clear boundaries can support the ordering of an emotionally chaotic inner world.

**Assessment of Families where Parental Mental Illness Is Diagnosed**

The impact of parental mental illness can have a variety of effects on each child depending on the health, stage of development and relationship with the family members.

In clinical settings, practitioners should undertake holistic assessments when parental mental illness are identified, to ascertain if they pose a risk to the child’s safety and wellbeing and whether these risks can be mitigated with appropriate support.

Holistic assessment should include:-

- The child’s wellbeing and development
- Parental capacity and the effect of mental illness on every day parenting
  Parental ability to meet the child’s needs
- Cultural background, medical history and presenting circumstances
- Family and extending support network or if they are isolated and have no help

Social, Family and Environmental Factors to be taken into consideration such as past or current experience of:-

- Substance misuse
- Domestic abuse
- Financial hardship
- Housing problems- such as inadequate housing, sofa surfing, hoarding, overcrowding
- Relationship problems
- Social isolation and language barriers
• Special vulnerable circumstances such as ‘witness protection’, vulnerable adults

These difficulties may increase vulnerability and have an impact on a child’s wellbeing.

Thorough assessment must include:

• focusing on the child and their needs
• providing children the opportunity to discuss their experience
• listening to and recording the child’s views on the situation
• identifying any children who have adopted a carer’s role
• treating children, parents/ carers as individuals
• considering the severity of a parent/ carer’s symptoms
• taking threats of suicide or threats to kill a partner or child seriously
• finding out whether the parent/ carer is accepting support from mental health services and assess whether this is having an impact on the child’s wellbeing
• seeking the views of colleagues from other agencies who are involved with the family, such as health visitors, teachers, GPs
• assessing factors increasing the children’s risk of harm, against protective factors which will increase the family’s resilience

**Protective Factors**

Protective factors can help reduce the risk to children’s health and wellbeing and these include:-

• Willingness to acknowledge own difficulties and accept support from services (statutory as well as voluntary agencies)
• Family and friends who are willing and able to provide support for the children and help with domestic chores such as providing meals and cleaning
• Availability and receiving additional support from other professionals who can monitor and alert services of any merging concerns if necessary, for example, a Health visitor informing a mental health practitioner of concerns following a recent home visit to the family
• Children having insight and knowing when to ask for help from professionals
• Good support network in the wider community such as from community social groups

Prioritising children’s needs

Professionals working with children and young people who have parents with mental illness, must maintain a focus on their children’s wellbeing.

Advocacy and mentoring

• Children and young people with parents with mental health problems should be given access to a safe place to talk to an advocate and/or mentor about their parents’ mental health and potential impact on their health and wellbeing.
• There should be a named professional/contact number so that children and young people can contact for support if needed in an emergency.
• Children may be wary about being offered therapy or counselling. Depending on their parents’ experiences, they may have negative associations with this kind of support. They may also have fears about developing mental health problems themselves, and think that being referred to a counsellor is a sign of mental illness (Cooklin, 2013).

Peer Support

Provision of peer support forums is an important safe place for children and young people, whose parents have mental illness, so that they can interact with other children in similar situations. It provides support mechanism for them knowing that they are not on their own. This can have a positive impact on children resilience and wellbeing if facilitated well. Positive impacts include:-

• Increasing self esteem
• Improving understanding of parental mental health issues
• Teaching communication and coping skills
Other peer support forums include Child Line, NSPCC, Barnardo’s etc which provide additional support for children and young people to express their feeling, talk about their experiences and share advice with others.

**Empowering children**

Children and young people should play a positive role in, and contribute to decisions about, their parent or carer’s care. They want to be involved in interventions and they want their views to be taken seriously.

- Giving children and young people accurate, age appropriate information about mental health problems can address any misconceptions or fears they may have and can give them the language to express themselves.
- Allowing children and young people distance from their parent or carer’s emotions and behaviours can enable them to develop their own thinking and emotions.
- Explaining a parent or carer’s mental health difficulties can be a platform for wider discussions about relationships and emotions in general.

Educating children about parental mental illness can have a number of benefits including:

- increasing the child’s resilience
- challenging the child’s misconceptions about mental health
- increasing the child’s understanding and empathy for their parent or carer
- improving communications between the parent or carer

**Family support**

Family members can be reluctant to discuss mental health with each other. Lack of communication can result in misunderstandings and may make children feel worried or alone.

Interventions which encourage families to communicate with each other can help everyone understand the impact of the mental health problems.
Families can benefit from meeting and sharing experiences with other families. This can:

- prevent relapses
- reduce feelings of isolation and stigma
- offer positive ways to interact with each other
- support more open discussion about mental health across the wider family.

Some interventions help family members to design and implement 'staying well' plans. This could include:

- sign-posting to other helpful services
- setting goals
- developing problem solving skills
- offering advice on managing stress
- recognising the early signs of a relapse.

The Roles of Multiagency Services/Professionals in working with Children, Young People and Families in Child Protection and Complex Cases

1. Children’s Services

In some cases it may be considered that a child and family are in need of support or protection. In such circumstances contact should be made with Children’s Services. Upon receipt of the contact, Children’s Services will, in partnership with relevant professionals and the family consider the best response to the presenting needs. This may include an early help response or a referral to social care. If a social care response is required and where there are children under the age of 18 who are considered to be ‘a child in need’ under Section 17 of the Children Act 1989, the Local authority has a duty to ‘safeguard and promote the welfare of children within their area who are in
need.’ Following a Child & Family Assessment, a Child In Need Plan may be developed.

Children’s Services also has a duty under Section 47 of the Children Act 1989 to investigate the child’s circumstances where they have ‘reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm,’ and to ‘take any action to safeguard or promote the child’s welfare.’ Local authorities have a duty to provide a level and range of services to safeguard children and promote their welfare. Consequently, a local authority has to investigate any concerns or allegations that suggest a child is likely to suffer physical, emotional or sexual abuse, or neglect, and to take action to prevent this. If the child is thought to be at risk of significant harm then a multi-agency strategy meeting, followed by an initial child protection conference (if concerns are upheld) will take place. If the conference thinks the child has been abused or injured or is at risk of harm, a child protection plan will be drawn up. This sets out what help will be provided to the child and how progress will be monitored. Children’s Services will allocate a social worker who will act as the key worker, responsible for coordinating the multiagency support being provided to the family, to reduce the risks.

2. The Health Visitor

The health visiting service, following a holistic risk assessment may offer an enhanced service provision which may result in additional contact with the mother and the child. The health visiting service will be continually considering any future sign-posting to other services, to support both adults and children and ensure that any impact of emotional behaviours, is not compromising the outcome for the child’s health, wellbeing and safety.

3. Community Perinatal Team and Care Coordinator

The Community Perinatal Team (CPT) or care coordinator from another Community Mental Health Team, can assess and coordinate mental health care for women who are pregnant or up to 1 year postnatal, who are at risk of or experiencing moderate – severe perinatal mental health difficulties. The CPT are a multidisciplinary team and can provide psychiatric assessment and
treatment, specialist perinatal mental health risk assessment and management as well as several therapeutic interventions aimed at reducing symptoms and supporting women with their mental health problems, whilst adjusting to becoming mothers.

For further information please contact:

Community Peri-Natal Team- 0300 124 0939 hpt.admin.perinatal@nhs.net

HPFT Corporate Safeguarding Team- 01727 804717 hpt.safeguardingteam@nhs.net