PSYCHOLOGICAL THERAPIES FOR WOMEN WITH PERSONALITY IN THE PERINATAL PERIOD

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WHAT IS THE PERINATAL PERIOD LIKE FOR WOMEN WITH PERSONALITY DIFFICULTIES?

- The need to interact with many health professionals
- Reflection on own childhood experiences, being parented and own attachment relationships
- Reduced access to some usual coping strategies
- Changes in interpersonal relationships
- Focus for others on baby and ‘not me’
- Physical/obstetric elements of pregnancy
- Hormonal changes increasing emotional sensitivity
- Triggering for familiar ways of thinking/feeling/relating
- Pressure to ‘be ok’ for when baby arrives
- Guilt attached to DSH or suicidal thinking
CAN WE HOLD THIS CONTEXT IN MIND…
WHAT ARE WE ASKING OF PEOPLE?

What do you and your service tend to ask of women?
WHAT DO WE ASK OF WOMEN?

- Respond to letters/phone calls
- Have a relationship with us
- Keep commitments
- Tell us what they think/feel
- Manage their relationships with us, with maternity, with social care, with health visitors, with their other children, with their baby
- Know what they want help with
MYTHS ABOUT THERAPY IN THE PERINATAL PERIOD

- It is not safe for a woman to have therapy when she is pregnant
- The pregnancy will give her a focus so she wouldn’t need therapy
- ‘Untreatable’ narratives = double whammy
- It’s not the right time to address difficulties as she needs to focus on her baby
- It’s not possible to have therapy with a baby in the room
IN YOUR SMALL GROUPS:

- Thinking about Psychological Therapy in the Perinatal Period for women with EUPD:
  - *Talk together about a woman or women who have benefitted from psychological therapy during the perinatal period (10 mins)*
  - *Talk together about the challenges in women accessing psychological interventions in the perinatal period (10 mins)*
WHAT MIGHT IT BE LIKE FOR WOMEN?

- The messages women receive from society, their families and friendship groups about their pregnancy and parenting their baby may influence their perceptions about accessing psychological therapy.

  ➢ What have women said to you about having therapy in the perinatal period?

- Women may feel guilty or ashamed for accessing support for their mental health particularly in the perinatal period where they may perceive that they should feel happy, excited and grateful. These feelings and ideas can sometimes get in the way of accessing psychological therapy in a timely way.

- As well as difficult feelings about accessing psychological therapy, women can often be more motivated than at other times in their lives to engage in psychological interventions, recognising the importance of optimising their mental health and/or their relationship with their baby.
Considering the different psychological therapies for women with personality and regulation difficulties during the perinatal period
What does this guideline suggest for women with Personality Disorder?

- Antenatal and postnatal mental health: clinical management and service guidance (CG192)
When a woman with a known or suspected mental health problem is referred in pregnancy or the postnatal period, assess for treatment within 2 weeks of referral and provide psychological interventions within 1 month of initial assessment.

Psychological and psychosocial interventions should be based on the relevant treatment manual(s), which should guide the structure and duration of the intervention.
When providing psychological treatment to people with borderline personality disorder, especially those with multiple comorbidities and/or severe impairment, the following service characteristics should be in place:

- An explicit and integrated theoretical approach used by both the treatment team and the therapist, which is shared with the service user.
- Structured care in accordance with this guideline.
- Provision for therapist supervision.

When providing psychological treatment to people with borderline personality disorder as a specific intervention in their overall treatment and care, use the CPA to clarify the roles of different services, professionals providing psychological treatment and other healthcare professionals.

When providing psychological treatment to people with borderline personality disorder, monitor the effect of treatment on a broad range of outcomes, including personal functioning, drug and alcohol use, self-harm, depression and the symptoms of borderline personality disorder.
When considering a psychological treatment for a person with borderline personality disorder, take into account:

- the choice and preference of the service user
- the degree of impairment and severity of the disorder
- the person's willingness to engage with therapy and their motivation to change
- the person's ability to remain within the boundaries of a therapeutic relationship
- the availability of personal and professional support

Give written information on therapies before starting to give an opportunity for them to discuss the therapy but also the evidence for the effectiveness of different types of psychological treatment for borderline personality disorder and any comorbid conditions.
NICE does not recommend one particular talking therapy. Some of the therapies highlighted are Mentalization Based Therapy (MBT), Dialectical Behaviour Therapy (DBT) and Cognitive Analytical Therapy (CAT).

For women with borderline personality disorder for whom reducing recurrent self-harm is a priority, consider a comprehensive Dialectical Behaviour Therapy Programme.

The use of these therapies necessitates adherence to the evidence base from which they come from. This necessitates they are offered to people in the form of full treatments.

Although the frequency of psychotherapy sessions should be adapted to the person's needs and context of living, twice-weekly sessions may be considered.

Do not use brief psychological interventions (of less than 3 months' duration) specifically for borderline personality disorder or for the individual symptoms of the disorder, outside a service that has the characteristics.
IT’S NEVER SIMPLE…

Depression

OCD

PTSD

Anxiety

D&A
Before starting treatment for a comorbid condition in people with borderline personality disorder, review:

- the diagnosis of borderline personality disorder and that of the comorbid condition, especially if either diagnosis has been made during a crisis or emergency presentation
- the effectiveness and tolerability of previous and current treatments; discontinue ineffective treatments.

Treat comorbid depression, post-traumatic stress disorder or anxiety within a well-structured treatment programme for borderline personality disorder.

Refer people with borderline personality disorder who also have major psychosis, dependence on alcohol or Class A drugs, or a severe eating disorder to an appropriate service.

When treating a comorbid condition in people with borderline personality disorder, follow the NICE clinical guideline for the comorbid condition.
The different approaches to consider
PSYCHOLOGICAL INTERVENTIONS

1. For the treatment of the MH difficulties
   - CBT
   - Schema Based Therapy
   - DBT informed work
   - ACT
   - Compassion focussed therapies

2. Targeting the relationship between Mum and baby
   - Circle of security
   - Video Interaction Therapies (VIPP, VIG, Seeing is Believing)
   - Attachment informed individual work
Cognitive behavioural therapy is a focused approach based on the premise that cognitions influence feelings and behaviours, and that subsequent behaviours and emotions can influence cognitions.
THERAPIES: DBT

- Dialectical Behaviour Therapy (Linehan)
- EUPD as a result of emotional dysregulation that leads to harmful coping and difficulties forming and maintaining relationships
- Early environment and temperament interaction means emotional regulation means are not acquired
- DSH as a way of regulating intense emotional distress
- Therapy as a way of acquiring skills not otherwise learnt in early and adult environment
- Wilson and Donachie (2018)
Mentalisation Based Treatment (Fonagy)

Based on the idea that disorganised attachment and a difficulty understanding the needs, feelings and intentions of self and other underpin personality based difficulties:

- Development of secure attachment with therapist through which mentalising becomes more possible
- Slowly understanding interactions with others and self increases the possibility for the person to know their ‘own mind’ and the ‘mind of the other’
- Importance of this for the ability to relate to baby and increase in relational demands in the perinatal period
Schema Therapy (Young)

18 early maladaptive schemas (complex patterns of thinking, feeling and relating)

Core patterns (‘self defeating’) that keep repeating across our lives

5 categories of emotional needs that all have but for some are not met as a child: connection, mutuality, reciprocity, flow and autonomy

Unhelpful coping modes block contact with feelings

Therapy (within and outside) as a way of getting needs met and letting go of unhealthy coping modes

http://www.schematherapysociety.org/
THERAPIES: CAT

- Cognitive Analytic Therapy (Ryle)
- Protocol based- either 16 or 24 sessions
- Looking at relationship patterns that have early life origins but are causing/contributing to distress in the present day
- Understanding how you learned to cope with intense/difficult feelings and how these ways may now be causing distress
- Therapeutic relationship as a means through which to better understand difficulties and find different ways of living
- Attempt to influence relationship patterns and application to relationship between parent-infant
- [http://www.acat.me.uk/page/home](http://www.acat.me.uk/page/home)
THERAPIES: CFT

- Compassion focussed therapy (Gilbert)
- For people that experiences high levels of self criticism or blame- e.g not experiencing joy etc. about a baby and then blaming oneself
- Using ‘old brain, new brain’ theory to promote use of our natural soothing system as a means to alleviate distress through generate compassion
- Inter connection of threat, drive and soothing ‘systems’- we have to help these work effectively for us
- Focus on ‘letting go’ of self blame and criticism
- [http://compassionatemind.co.uk/](http://compassionatemind.co.uk/)
- Cree (2010)
Approaches for women with EUPD

- Consider the person, the approach, the history and the timing

- Any individual work must have a relational focus (unless there is significant self harm)
  - Schema therapy
  - Mentalisation based therapy
  - CAT

- Consider the role of an Emotional Coping Skills group programme (based on DBT) that is open to antenatal and post natal women
PSYCHOLOGICAL THERAPIES FOR THE MUM-BABY RELATIONSHIP
A big part of the Perinatal Team’s role is to think with women about the relationship with their baby.

There are well researched links between PD in parents and difficulties in the parent/infant attachment.

Outcomes for the children of parents with PD are often less favourable.
Parents are responsible for enabling their baby to:

- Experience, express and regulate emotions
- Form close interpersonal relationships
- Explore the environment and learn

The first model of relating that a child experiences (and often the most powerful one)
SECURE ATTACHMENTS

- Develops when the caregiver responds *sensitively* to the baby’s signals
- Provides a safe base from which the infant can explore his/her environment
- Enables development of positive beliefs about self and others
- Is the foundation for all future relationships
- Helps development of self regulation
- Protects against future adversity
INSECURE ATTACHMENTS

- Develops when primary caregiver is insufficiently responsive and attuned to the baby or infant’s signals
- Leads to negative beliefs about oneself and others
- Hinders the development of self-regulation
- Leads to difficulty making reciprocal relationships
- Increases likelihood of MH problems later in life
CHALLENGES FOR WOMEN AS PARENTS

- Increased reliance on harmful coping to regulate emotional distress:
  - DSH
  - Substance Misuse
  - Avoidance

- Difficulties in managing relationships:
  - Increased prevalence of DV
  - Difficulty setting limits with others
  - Pre-occupation with self OR pre-occupation with ‘other’
PSYCHOLOGICAL CAPACITIES FOR ‘GOOD ENOUGH’ PARENTING

The capacity to:

- Manage one’s own distress and anxiety without becoming angry, dysregulated or frightened
- Respond empathically and confidently to another person’s distress
- Plan and think ahead
- Work with other adults involved in the child’s welfare (family, professionals, parents of peers)
- Perceive vulnerability with compassion and concern
- Ask for and value help
- Tolerate negative affects (including anger, disappointment, fear, boredom, frustration, minor pain) without taking impulsive action or assuming the worst
- Tolerate waiting for own needs to be met
- Experience pleasure and to have a sense of humour

*Adshead, 2015*
CHALLENGES IN PARENTING

META ANALYSIS CONCLUSIONS

- Interaction style
- Emotion Recognition
- Activity Structuring
- Experience of higher stress, lower self competence and lower satisfaction
- Mind- mindedness
- Over protection (of ‘older children’)
Women often motivated to make positive changes in pregnancy

Women genuinely want to give child a better experience of childhood than they had themselves

Supportive partner or family member may make a difference

Women who have made some progress as a result of psychological therapy previously are often able to build on this

Women who engage well with professionals
Helping parents to keep the baby in mind

Through interventions aimed at ‘creating space’ by the treatment of the PD difficulties

Through interventions specific to that parents relationship with their baby

Promote and increase Reflective Capacity: the capacity to understand that one’s own or another’s behaviors are linked in meaningful, predictable ways to underlying mental states, to feelings, wishes, thoughts, and desires. In other words, reflective capacity refers to the awareness that an individual’s behavior is a reflection of underlying, likely unobservable, changing, dynamic intentions and emotions.
PARENT-INFANT INTERVENTIONS

- Circle of security
- Seeing is Believing (Video feedback with Narrative Therapy ideas)
- Video-Feedback Intervention to Promote Positive Parenting and Sensitive Discipline (VIPP- SD)
- Video interactive guidance- VIG.
- Parent-Infant Psychotherapy
8 group sessions of 1.5 hours each

Sessions utilize dvd footage, handouts and reflective discussion

Based on attachment theory which is used to offer a framework to comprehend children’s fundamental relationship needs

Therapists act as safe base for group members to explore their own struggles and how these present in their relationships with their baby/child
Secure Base

- Protect me
- Comfort me
- Delight in me
- Organize my feelings

Safe Haven

Support My Exploration

- Watch over me
- Delight in me
- Help me
- Enjoy with me

Welcome My Coming To You

Always: be BIGGER, STRONGER, WISER, and KIND.
Whenever possible: follow my child’s need.
Whenever necessary: take charge.
The Circle of Security intervention aims to help develop the following relationship capacities:

- Observational Skills
- Reflective Functioning
- Emotional Regulation
- Empathy

Based on assumption that change comes from parents developing specific relationship capacities rather than learning techniques to manage behaviours.

Mothander, Furmark, Nenader (2017)
VIDEO INTERACTION TO PROMOTE POSITIVE PARENTING AND SENSITIVE DISCIPLINE (VIPP-SD)

- Video feedback to promote positive parenting. It is based on attachment theory and social learning theory.
- Home-based (Includes 7 home visits, 2-3 week intervals)
- Focused on the here and now.
- Parent is filmed in specific activities with their child and feedback is then given on this in the following session - the whole clip is watched but the clinician stops it at planned moments to give specific feedback
- Focus on the strengths and positive moments and these are reinforced
- Current trial at Imperial trialling this intervention with parents who have a diagnosis of EUPD
SEEING IS BELIEVING

- Videos made of parent with baby to highlight ‘sparkling moments’
- Focus on moments of attunement (however brief)
- Watched together and new narratives of the relationship and woman as a mother are built and strengthened
- Ideas from Narrative Therapy used to make new relationship frames possible
Focus on improving communication in relationships

Families/parents are supported to think about what they would like to change before any of the interactions are filmed

Adult-child interactions are filmed and edited to produce a short film that focuses on the positive interaction

The clips are filmed and then reflected on by parent and clinician

Moments of attuned/sensitive care giving are highlighted and encouraged

The observing of this is thought to improve confidence and promote more of the same interactions
The parent-infant therapist will focus on building relationships and trust with both parent and baby with the aim of:

- Supporting the parent to understand their baby’s needs and responding sensitively to them
- Keeping the baby actively engaged emotionally with his/her parent
- The relationship between client and therapists is used to a base from which the parent can explore their own relationship experiences concurrently whilst they are developing their relationship with their baby
Fantasy Psychology Provision:

In your small groups- based on the session today and your experience:

- Identify 5 key things you would like to see in the psychology provision for women with EUPD in Perinatal Services (10 mins)
FOSTERING CLINICALLY SOUND CREATIVITY…

“The absence of empirical evidence for the effectiveness of a particular intervention is not the same as evidence for ineffectiveness”

- How do you make a cup of tea?
SPECIFIC CONSIDERATIONS

- **Managing endings and supporting transitions**
- Anticipate that withdrawal and ending of treatments or services, and transition from one service to another, may evoke strong emotions and reactions in people with borderline personality disorder.

*Ensure that:*
- such changes are discussed carefully beforehand with the person (and their family or carers if appropriate) and are structured and phased
- the care plan supports effective collaboration with other care providers during endings and transitions, and includes the opportunity to access services in times of crisis
- when referring a person for assessment in other services (including for psychological treatment), they are supported during the referral period and arrangements for support are agreed beforehand with them.
IN SUMMARY

- Psychological therapy can be very helpful to women with personality disorder in the perinatal period.
- Therapy would almost always take place weekly and will be longer than 3 months in duration.
- There may be a focus on the difficulties associated with the personality disorder or the parent-infant relationship and often both of these.
- It is not effective to treat a singular symptom (e.g., anger) outside of a therapy that addresses the longer-term difficulties.
- If a woman is self-harming or having suicidal thoughts, these would be the priority for the beginning of treatment.
- The perinatal period may be a time where a ‘full’ treatment for the personality disorder is not possible (timing, need to focus on parent-infant relationship) so it may be that a woman engages in therapy and is then referred on for further therapy.
QUESTIONS, COMMENTS, THOUGHTS…
Leading Perinatal teams team that work with women who have Personality Disorder
WHAT ARE THE CHALLENGES FOR TEAMS WITH THIS CLIENT GROUP?