Case report

ABSTRACT

Background
We report a case of a 29-year-old woman with borderline personality disorder and emotional dysregulation, who attracted much attention from children's services and mental health professionals after her decision to return to work two weeks postpartum. Personality disorder labels carry a lot of stigma, highlighted by the fact that if a man chose to return to work soon after the birth of his baby, this would be widely societally accepted, despite them undergoing many of the same hormonal changes as the mother.

Aims
This report explores some of the societal reasons for the stigma associated with mental health diagnoses, and how this can detrimentally impact the care and health of a mother with a diagnosis.

Case outline
A mother with a previous diagnosis of BPD, anxiety, and depression, is stable on medication. She gives birth to her second child, and chooses to return to work from home 2 weeks after she is physically recovered from the birth, as it allowed her some headspace to cope with the changes of having a new baby. This attracted attention from social care, and she was subject to many social investigations, all of which found that her children are happy, healthy, and well-cared for, despite the concern.

Conclusion
This case highlights some of the issues surrounding diagnostic bias in personality disorders, and why these might exist. It suggests reasons for the differences, and proves why these are baseless, and therefore shows some of the problems that over-medicalising and stigmatising mental illness can lead to.

Introduction

We report a case of a 29-year-old woman with borderline personality disorder and emotional dysregulation, who attracted much attention from children's services and mental health professionals after her decision to return to work two weeks postpartum. Her coping mechanism was to work, raising questions as to why she was deemed mentally unwell and emotionally dysregulated, purely because she was not following societal norms surrounding motherhood. If a father returned to work immediately following the birth of his baby, this would be widely societally accepted, nor would attract any professional intervention. We will explore why these biases exist. This case report outlines the sexism and stigma that permeates through borderline personality disorder diagnoses, research, management, and attitudes to conventional motherhood and childcare. This report refers to the birth-giver as 'mother,' and sperm-giver as

‘father,’ but acknowledges that this does not account for the diversity of family dynamics today.

A diagnosis of borderline personality disorder (BPD) involves trouble controlling and expressing their emotions, impacting cognition, affect, interpersonal functioning, and impulse control, causing significant distress and impairment to functioning(1). Patient’s may have intense, unstable relationships, with fear of abandonment, and often are comorbid with other mental health conditions. It is challenging to diagnose, due to difficulties delineating simple personality quirks, as well as variability in symptom presentation, and differences in cultural norms and subjectivity(1). Its aetiology is unclear but appears to be multifactorial, incorporating both genetics and adverse childhood experiences. It is treated with psychotropics and talking therapies(2). BPD is associated with considerable societal and medical stigma, with patients often assumed to be ‘difficult to treat.’ DSM-5 classification states that BPD is three times more likely to be diagnosed in women. This is potentially due to social gender stereotypes that women are more likely to be more ‘emotionally labile’ than men(3). This contributes to research and reporting bias, as well as sex differences in the manifestation of symptoms leading to diagnostic bias(4,5). This is potentially problematic for many women who are given a pathological label when their personality may simply just be outside of societal norms.

It is obvious that a mother has an important role to play in the immediate care of a baby, and biological mechanisms have been evolutionarily conserved so the mother will nourish and grow the unborn child, and be present at birth. Maternal bonding strategies exist for the survival of the baby, for example through lactation and providing warmth and comfort(6). It has been shown that women do not spontaneously show maternal care, but the brain requires priming by pregnancy hormones(7). This include b-endorphin, corticotrophin-releasing factor, oxytocin, prolactin, and arginine vasopressin, which induce changes in neuropeptide expression, and thus maternal behaviours(8). This neuronal plasticity allows women to adapt to motherhood and raise their child, in whichever way this means for them(9,10). It is less widely studied(11) and accepted however, that paternal brains undergo a similar plasticity change, in response to similar hormones (OT, CORT, PRL) stimulated by father-infant and father-pregnant person interactions(12,13). This allows fathers to interact with and bond with their babies, despite not experiencing the pregnancy themselves. Research suggests that maternal and paternal hormonal and neuronal experiences are somewhat comparable(14).

This case questions why, if the biological mechanisms of bonding are similar, why a woman is diagnosed as pathological and neglectful for her child if she chooses to provide for the baby by working, if the father cares for the baby’s needs. Why did this activate child safeguarding, simply because the woman didn’t follow traditional caregiving, and the father was? Personality disorders carry a lot of medical stigma, and this could have contributed to the assumption that her actions were causing distress to her child, when this wasn’t the case. Why, when fathers (more commonly) return to work soon after birth, is this never probed and is not labelled as pathological. This report acknowledges that bias in BPD diagnosis a wide and active field but should be considered in this case.

CASE DESCRIPTION

Our case describes a 29-year-old woman with two children. Her medical history as a child was insignificant, she lived with both parents, with no problems reported within the family home. During secondary school, she described being bullied, leading to some low moods and self-harming (cutting) behaviours. At age 20 an urgent review revealed a suicide attempt, very low mood, and more self-harming behaviours, following a relationship break up the month before. An initial diagnosis of anxiety and depression was made, and an SSRI commenced. Four years later, she reports challenges with work and is sensitive to criticism, and she describes feeling on a 'different wavelength to others.' A possible episode of mania where she was found drinking on the streets and feeling 'sped up,' led to the SSRI being reduced. Aged 25, her first pregnancy precipitated some anxieties, which resolved following a healthy delivery, and her mood stabilised. She had lots of support with her baby, including supportive parents and husband. Potential postnatal depression was treated with a course of CBT, which appeared to be successful. A year after this, her marriage broke down and she begins a new relationship with a male with a history of domestic violence, alcoholism and mental health problems, and she had begun self-harming again. An 'uncontrollable urge to harm herself' led to the diagnosis of BPD, and she also became pregnant again unexpectedly with the new partner. She struggled in the new relationship along with more severe physical effects from pregnancy (hyperemesis, seizures, PPROM, anaemia). She was referred to the perinatal mental health team and began aripiprazole. She disclosed relationship problems, including controlling behaviour, conflict, trust issues, and emotional abuse. Psychological therapy was commenced, and she did well, learning about her triggers and coping techniques for her emotional dysregulation and intense rage. She gave birth, and broke up with the partner, but then quickly reconciled. She then decided to go back to work as soon as she was physically healed from her pregnancy, working from home so she was still able to meet the baby's physical needs. She discussed feeling unable to care for the baby's emotional needs, but the father is meeting those. Going to work allowed her to make time for herself, and helped feelings of isolation in her own home, as well as taking the pressure off financial worries. Currently, she presents well, is stable on medication and is engaging well with mental health and social care services. She can ask for help when needed and has effective coping strategies. Despite concerns around her relationship, there was no clear reason for child safeguarding risk. Both her children are meeting all their developmental milestones, are thriving and are healthy.

DISCUSSION

This case shows how professionals often automatically assume neglect when a mother does not care for her children in a stereotypical way. While this does happen, here both children were being adequately cared for practically and emotionally, with responsibility split with the fathers. No one questioned the males caring for the children's needs. But because the woman is providing practically for the children, a home and stable

finances, this appears ‘abnormal’ and was not quickly accepted by professionals, until social care had investigated and concluded that the children were not neglected and did not require any help. Why was this family subjected to the inevitable unnecessary stress caused by the involvement of children’s services? This segment examines the reasons behind this bias.

Diagnostic bias exists within the literature: searches on PubMed and OVID yielded no results about why fathers return to work and incidence of psychiatric illness, or why some leave their families. Why has this not been scrutinised? Women are often labelled with psychiatric illnesses if they are not stereotypically present for their babies, while fathers are not questioned? This case showed diagnostic bias, as she had no clinically significant distress, maladaptation, or impairment of functioning(15), a requirement for BPD diagnosis, she just chose to parent differently to societal expectation. She did struggle in romantic relationships but had a strong bond with her children, and is clearly successful at work. While she suffered from other mental illnesses and emotional dysregulation, it seems unfair that this BPD label contributed to unnecessary professional involvement and may reflect over-diagnosis. BPD is predominantly diagnosed in women(5), despite studies showing no sex differences in prevalence(3), and that these differences may be perceived, rather than actual. This could stem from unconscious clinician gender stereotyping and sexism(4). Women are also much more likely to seek treatment(3), contributing to the perceived difference. Research is needed to understand why so many women are labelled unwell when they may just be requesting help for non-pathological issues. While having a label can be helpful by allowing access to treatment, which obviously did help the woman in our case, it also opens you to stigma and judgement, which also happened here and can be detrimental.

Some would argue that females have a biological drive towards motherhood, whereas males don’t(16). While men and women interact with their infant in stereotypically different ways(16), these theories are observational and are not well-researched(13,17), therefore should be interpreted with caution. This is problematic and male bonding interactions should be a research priority. Men and women undergo similar hormonal and neuroplastic changes in response to birth, and hormonal responses are similar(14,18) to infant cues. Therefore, the notion that women should ‘stay at home to care for the baby because they are hormonally bonded’ and the father goes out to work as the ‘provider’ of the family is unfounded. This concept no longer applies to many families in today’s world, yet society holds this view, and retains judgement. Women are not ‘inherently maternal’ as some believe, and bonding is not spontaneous, and requires brain priming with pregnancy hormones (8). This highlights how women should not be forced into a maternal role if their personality differs from this. In contrast, in primates it has been proved that pregnancy hormones are not necessary for maternal behaviour, conceivable to nurture infants without ever being pregnant, extrapolating that men are able to bond with their infants despite not being pregnant(6). Being the birth-giver should not and does not automatically resign you to a caregiver role, one must choose to love and care for their infant. Variability in parenting is multifactorial, and is attributed to differences in neuroplasticity and endogenous levels of hormones(19), as well as polymorphic variations in target genes associated with reward systems(20). Not every parent will therefore respond in the same way to stimulus, and

that we should stop assuming that parenting and maternal care-giving behaviours are biologically or hormonally-driven. In this case, the woman is being unnecessarily scrutinised, despite her children being well looked-after, for parenting and bonding differently to societal expectations.

Conclusion

We must shift the focus away from the mother-infant relationship to the parent-parent-infant relationship. Fathers experience similar changes to mothers after birth, and can equally bond, interact with, and care for the baby, having an impact on the child's long-term development (16). No research yet exists surrounding paternal roles and psychiatric illness in 'absent' fathers, yet mothers are quickly labelled as 'unwell' and requiring child support input if they do not meet societal expectations. Why do we have different criteria for fathers? Further knowledge is also needed to illuminate the biological changes that occur in parents during pregnancy and birth, though ethical restrictions limit studies on pregnant people (with fewer constraints on non-pregnant fathers!). Clinicians must be aware not to let their unconscious vias affect diagnoses and should only involve child services If a child's needs are unmet, there is no need to cause stress unnecessarily. Societal views must stop viewing women as the primary caregiver, they are only the birth-giver. Finally, this report did not examine non-nuclear families, such as sperm donation, adoptive parents, and non-heterosexuals. As family models evolve, there is even more reason to change cultural attitudes. Both parents can equally care for the baby and have the same hormonal drives, so there is no reason to judge a mother over a father for choices that work for their family.

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