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Review on borderline personality disorder and pregnancy: Possible interventions to improve outcomes

Abstract

Background: Borderline personality disorder is the most extensively studied area in psychiatry. Poor pregnancy outcome is evident from studies available. Obstetricians and mental health teams experience multiple challenges due to the nature of this personality disorder. However, effective interventions to manage women with borderline personality disorder in the antenatal and perinatal periods are yet to be formulated. This review emphasizes on challenges faced by care providers and the authors 'views on forming effective measures to improve the outcomes.

Methods: The review was done using the available articles using the keywords "Borderline personality disorder" and "pregnancy". PubMed, PsycINFO, CINAHL, EMBASE and CENTRAL were used to search the articles. 99,500 articles were found. Only three were selected for narrative review due to their relevance.

Results: Early sexual debut and unintended pregnancies were increased. Further, almost all perinatal complications were noted except for post-partum hemorrhage and the need for induction of labour. Parenting issues and separation from children due to safety issues by authorities were noted. Managing women with BPD imposes stress on the healthcare system due to core symptoms of the BPD. Communication strategies and strong liaison with community and hospital teams may alleviate the tension in the healthcare system.

Conclusion: Accumulating evidence suggests the complexity of antenatal issues. Perinatal outcomes have consistently been poor in women with a borderline personality disorder. Further, effective strategies to alleviate the outcomes of women need to be designed, focusing on the characteristics of the nature of the disorder.

Keywords: borderline personality disorder, pregnancy, antenatal care, postnatal care

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Abbreviations: BPD, borderline personality disorder; MHCP, mental health care providers; HCP, health care providers; CI, confidence interval; OD, odds ratio; NICU, neonatal intensive care unit; SCN, special care nursery; A& E, emergency departments; GP, general practitioners

Introduction

Borderline personality disorder (BPD) is characterized by impaired relatedness (unstable relationships with others, identity disturbance, and chronic emptiness), affective dysregulation (mood lability, excessive anger, and efforts to avoid abandonment by dependent behavior) and behaviour dysregulation (impulsiveness, suicidality, and self-harming behaviour). Diagnosis is by extensive psychiatric evaluation, including the interview of family members and accessing the previous medical records.

Accumulating clinical data suggest that the onset of borderline personality disorder (BPD) occurs in adolescence or early adulthood.[1] In the last two decades, longitudinal prospective studies also found that most patients experience remission of the disordered.[2,3] The absence of drug abuse, child abuse, social and cognitive functions and absence of anxious cluster disorder are more likely to remit and maintain the emission field.[3]

Many theories suggest that the genesis of BPD has genetic and environmental factors. Prenatal adversity or exposure to adverse emotional and physical stresses intrauterine causes BPD.[4,5] The debate will be unanswered as many of the factors are interrelated and barely controllable. Further, the vicious cycle of impoverishment, poor education and teenage pregnancies and child abuse is age-old dimension with few effective interventions.

Obstetricians and mental health care providers (MHCP) have a magnitude of challenges when managing women with BPD. Preventing adverse perinatal outcomes is the main objective of healthcare providers (HCPs). But poor compliance with medical treatment is a common phenomenon in women with BPD. Further, associated co-morbidities such as eating disorders, alcoholism and drug dependence make it nearly impossible to achieve the objectives of the antenatal care.[6] Nevertheless, the stress on HCP is enormous due to women with BPD due to impulsiveness, dependence and dramatic presentations.[7]

This article summarizes the reported obstetric outcomes and discusses the possible strategies for efficient healthcare provision.

Methods

Relevant articles were searched using the keywords "Borderline personality disorder" and "Pregnancy". PubMed, PsycINFO, CINAHL, EMBASE and CENTRAL were used to search the articles. 99,500 articles were found. Only 3 case-control studies which describe only women with BPD were selected due to the relevance to the narrative review.

Results

(Table 1)

Table 1 Pregnancy outcomes in women with BPD

Study	Authors	Sample size	Complication	Confidence interval (CI)	Odd ratio (OR)
Pregnancies, Abortions and Births in Women with and without borderline personality disorder	Natacha M.et al	379	Sex by age 14	1.58	0.90–2.77
			Elective abortions	1.59	0.94–2.71
			One unplanned pregnancy	3.53	2.07–6.03
			Repeated unplanned pregnancy	2.15	1.23–3.75
Borderline Personality Disorder in the perinatal period: early infant and maternal outcomes	Gaynor Blankley et al	42	APGAR < 7	2.17	1.06-4.41
			Resuscitation	2	1.03-3.91
			Birth weight <2500g	1.33	0.62-2.87
			Birth <37	2.43	1.16-5.09
			SCN/NICU*	2.47	1.30-4.69
			Referral to DHHS*	116	60-225
			Referral to child first*	112	53-238
Effect on Borderline personality disorder on obstetric and neonatal outcome.	Valerie Pare-Miron et al	989	premature rupture of the membranes	1.4	1.07-1.83
			Chorioamnionitis	1.65	1.14-2.39
			Gestational diabetes	1.45	1.13-1.85
			Venous thromboembolism	2.11	1.12-3.96
			Caesarean delivery	1.44	1.26-1.64
			Preterm birth	1.54	1.29-1.83

*NICU- Neonatal intensive care unit SCN-special care nursery Child first -publicly funded in-home parental support system in Victoria, Australia, DHHS-Victorian department of human services, Victoria, Australia.

The table summarizes the pregnancy and perinatal outcomes in women with borderline personality disorder in 3 case-control studies.

Unintended pregnancies

Unintended pregnancies and repeated unintended teenage pregnancies were common with women with BPD, even corrected for substance abuse and severity of BPD scores(8). Coercion to sexual activity was included in this study.[8]

Antenatal complications

Sparse evidence on the antenatal complications. Gestational diabetes and hyperemesis gravidarum are a few reported complications.[9,10]

Perinatal outcomes

Preterm birth, low birth weight, premature preterm rupture of membranes, chorioamnionitis, neonatal resuscitation and admission to NICU were reported in women in BPD.[9,11] The causation could be multifactorial, including poor socioeconomic conditions and physical and emotional abuse.[12,13]

Parenting issues and children's outcome

Emotional unavailability, lack of control, re-living in the past experience, poor coping mechanisms, and over-protecting behaviour were described by parents with BPD.[14–17] Overall poor children's outcome was noted in mental health and cognition. Further, the increased need for support for these families has been described.[17]

Discussion

An increase in the number of patients presenting with (BPD) causes unprecedented pressure on the healthcare system.[7] further, patients with BPD have a tendency to overuse hospital and medical facilities, inclusive of Accident and Emergency departments (A & E), family doctors and General Practitioners(GPs). The author believes that repeated feelings of emptiness and associated comorbid axis disorders have a role behind repeated presentations. Further, the inability to deal with the day-to-day crisis and amplified suicidal ideation result in frequent healthcare-seeking behaviour.

Pregnancy is associated with exacerbations of BPD as it can evoke the previous experience as a child, which may further impair their coping abilities during pregnancy, and this can be continued during puerperium and far beyond. Support systems should extend to women with BPD till she enters remission or children as adequately taken care of.

Children with women with BPD have a high propensity to develop antisocial behaviours and cognitive impairments. Children should be screened regularly, and psychotherapy needs to initiate early. Support for families with BPD is costly as the problem goes from generation to generation, and effective interventions need to be planned immediately. Contraception needs to be promoted as unwanted pregnancies are repeatedly common in such women.

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Consequently, women with BPD require a constant and unlimited allocation of obstetric and psychiatric resources, together with targeted care plans. Care plans are highly individualized due to various associations with BPD. However, Women with BPD might be prone to frequent self-referrals and self-diagnosis of conditions and presenting frequently to GP to A&E. Frequent association with drug dependence, smoking and alcohol mandate the usage of drug and alcohol services. Nevertheless, deferring such services is common among women with BPD.

However, multiple limitations with the provision of core for such patients. Many patients refuse the hospital mental health team as conflicts during the previous admission. Hence, a comprehensive assessment is impossible during hospital admission. Diagnosis of BPD marginalized the women as BPD is commonly used unanimously with "aggressive" and "antisocial". This has rendered the relationship with the diagnostic team quite delicate. Frank discussion with the women at the time of the diagnosis is necessary to avoid such unpleasantries to the patient. However, this task cannot be expected to be fulfilled fully due to cognitive dysfunction in women with BPD.

Intimidation and violence against of HCPs are reported in the literature. This complicated the encounter of women with BPD in the healthcare system. At the same time, healthcare professionals are discouraged by the complex management of patients with BPD, which, in combination with their tendency to challenge or make unwarranted allegations against HCPs, results in burnout. Proposed causality is that the reason to produce a false allegation is to create a defence or to get compassion and attention.[18] Nonetheless, it is also likely that some healthcare professionals might have some preconceived ideas about people with BPD, which might reduce the depth of health careers' empathy towards these patients.

Poor attendance for antenatal visits, declining proposed investigations and frequent change in health care providers pose challenges for obstetricians to provide due care. Women with BPD express impaired relatedness, which can cause women to be attached to the HCPs. This works as a double-edged sword as it may increase compliance, and the clinician may be under stress due to the requests of the women. The strain on the doctor-patient relationship is determined by the underlying 'Abuse' scheme of patients with BPD who expect from others and are thus signals of relational wound.[19] It is mandatory to exhibit the boundaries in the initial consultation and make women independent during antenatal care. Authors suggest the presence of more than one person (2 obstetricians or a midwife) during consultation might help to lay the boundary as the patient may not relate to one person.

Consequently, a chronic feeling of inadequacy translates to dissatisfaction with any therapy and healthcare professionals. Hence, in the authors' experience, any attempt to establish a long-term therapeutic relationship with BPD patients might have limited outcomes. Frustration in healthcare professionals aiming to create an enduring therapeutic alliance with patients with BPD happens as these patients tend to have interpersonal biases.[20] Therefore, social interactions with primary careers result in dissatisfaction of people with BPD with any medical or psychiatric plan set up for them. Consequently, community teams, general practitioners and hospital staff feel hopeless due to recurrent readmissions of people with BPD and the lack of definitive treatment for such pathology. Authors suggest debriefing by a team in cases of recurrent admission without apparent pathology and referral to community services to alleviate the stresses from both sides. However, exploring possible pharmacotherapy and psychotherapy at the time of admission need to be considered. However, arranging such a service during A & E admission is impractical. The author believes such services may need to be considered in future due to the increasing magnitude of the BPD.

BPD could be a manifestation of chronic stress. Authors postulate that identification of high-risk populations through school programmes and initiation of secondary prevention protocols should be a key measure to prevent the tension in healthcare systems. It might include promoting self-empowering thinking patterns in teenage girls. Further, the introduction of long-acting contraception in young women will prevent them from being exposed to stress as young mothers.

The author believes that attention to BPD in women of reproductive age needs significant political movement and funding to make a difference swiftly.

Conclusion

Poor obstetric outcomes are proven beyond doubt in women with BPD. However, the challenges healthcare providers encounter are diverse due to the characteristics of the BPD. The antenatal and postnatal period is particularly challenging due to the exacerbation of BPD and other associated psychiatric issues. Effective strategies need to be developed to break the vicious cycle of BPD. Offspring of BPD need attention from early childhood to prevent creating an antisocial personality in later life. This task needs national and international attention due to frequent failures encountered irrespective of multidisciplinary care.

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Conflicts of interest

Author declares there is no conflict of interest exists.

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