

Policy

Clinical Guideline

Personality Disorders and Severe Emotional Dysregulation in the Perinatal Period Clinical Guideline

Policy developed by: SA Maternal & Neonatal Clinical Network

Approved SA Health Safety & Quality Strategic Governance Committee on:

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Summary Clinical practice guideline for the management of women with personality disorders and severe emotional dysregulation in the perinatal period

Keywords Borderline personality disorder, BPD, emotional dysregulation, dialectical behaviour therapy, mentalisation based therapy, MBT, DBT, personality disorders and severe emotional dysregulation in the perinatal period, clinical guideline

Policy history Is this a new policy? **N**
Does this policy amend or update an existing policy? **Y 1.0**
Does this policy replace an existing policy? **Y**

Applies to All SA Health Portfolio
All Department for Health and Ageing Divisions
All Health Networks
CALHN, SALHN, NALHN, CHSALHN, WCHN, SAAS

Staff impact All Staff, Management, Admin, Students, Volunteers
All Clinical, Medical, Nursing, Allied Health, Emergency, Dental, Mental Health, Pathology

PDS reference CG223

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2.0	07 Sep 2015	Current	Reviewed

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South Australian Perinatal Practice Guidelines

personality disorders and severe emotional dysregulation in the perinatal period

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Note

This guideline provides advice of a general nature. This statewide guideline has been prepared to promote and facilitate standardisation and consistency of practice, using a multidisciplinary approach. The guideline is based on a review of published evidence and expert opinion.

Information in this statewide guideline is current at the time of publication.

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Health practitioners in the South Australian public health sector are expected to review specific details of each patient and professionally assess the applicability of the relevant guideline to that clinical situation.

If for good clinical reasons, a decision is made to depart from the guideline, the responsible clinician must document in the patient's medical record, the decision made, by whom, and detailed reasons for the departure from the guideline.

This statewide guideline does not address all the elements of clinical practice and assumes that the individual clinicians are responsible for discussing care with consumers in an environment that is culturally appropriate and which enables respectful confidential discussion. This includes:

- The use of interpreter services where necessary,
- Advising consumers of their choice and ensuring informed consent is obtained,
- Providing care within scope of practice, meeting all legislative requirements and maintaining standards of professional conduct, and
- Documenting all care in accordance with mandatory and local requirements

Explanation of the aboriginal artwork:

The aboriginal artwork used symbolises the connection to country and the circle shape shows the strong relationships amongst families and the aboriginal culture. The horse shoe shape design shown prior to the generic statement symbolises a woman and those enclosing a smaller horse shoe shape depicts a pregnant women. The smaller horse shoe shape in this instance represents the unborn child. The artwork shown before the specific statements within the document symbolises a footprint and demonstrates the need to move forward together in unison.



Australian Aboriginal Culture is the oldest living culture in the world yet Aboriginal people continue to experience the poorest health outcomes when compared to non-Aboriginal Australians. In South Australia, Aboriginal women are 2-5 times more likely to die in childbirth and their babies are 2-3 times more likely to be of low birth weight. The accumulative effects of stress, low socio economic status, exposure to violence, historical trauma, culturally unsafe and discriminatory health services and health systems are all major contributors to the disparities in Aboriginal maternal and birthing outcomes. Despite these unacceptable statistics the birth of an Aboriginal baby is a celebration of life and an important cultural event bringing family together in celebration, obligation and responsibility. The diversity between Aboriginal cultures, language and practices differ greatly and so it is imperative that perinatal services prepare to respectively manage Aboriginal protocol and provide a culturally positive health care experience for Aboriginal people to ensure the best maternal, neonatal and child health outcomes.

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Introduction

- > Personality disorders are a set of chronic, non-psychotic disorders that affect thinking, emotions, mood and behaviour in a variety of ways. Personality disorders are generally believed to stem from a combination of genetic and environmental factors present in early life and throughout childhood¹
- > Amongst the personality disorders, the most prevalent and concerning for women in perinatal period is Borderline Personality Disorder (BPD). This guideline is written to address its major associated features. The guideline may also be useful in helping women who have difficulty in regulating their emotions, although they do not have sufficient features of BPD for a full diagnosis

Borderline personality disorder

- > Women with a diagnosis of BPD may have many complex traumas in their past, including verbal, physical and sexual abuse², although more recently a variety of other causes such as invalidating parenting style perhaps with a greater or lesser genetic predisposition have been postulated⁴
- > Pregnancy, childbirth and / or managing a crying infant may evoke many issues for these women, which in turn will cause difficulties for them and often for their carers. There may be an increased risk of negative birth outcomes⁵. Whilst women with BPD may be extremely distressed at times and seek help urgently, they may also back away from ongoing care and fail to re-attend for follow-up appointments
- > The major associated features of BPD are:
 - > Affective (mood) disruption
 - > Identity problems
 - > Poor impulse control (including self-harm and suicide attempts)
 - > Persistent difficulties in interpersonal functioning^{2,6}
 - > Transient paranoid ideation and / or dissociation
- > **Aboriginal women should be referred to the aboriginal health professional as soon as practicable to support their care**

Perinatal assessment and referral

Antenatal care

- > Complete the personal history section of the South Australian Pregnancy Record, including mental health history
 - > Establish who is responsible for the woman's mental health care throughout pregnancy and postpartum
 - > Document details of any existing mental health or community supports e.g. general practitioner, psychiatrist, psychologist, social worker, mental health case worker, Anglicare, FamiliesSA, local community centres
- > Complete the Edinburgh Postnatal Depression Scale (EPDS) and psychosocial risk questionnaire (Questionnaires should only be used by appropriately trained staff)
- > Assess the need for referral to any other services e.g. Social Worker, Mental Health liaison, Case discussion meeting, General Practitioner, psychologist
- > Expectant mothers with a diagnosis of BPD should have a multi-agency management plan that identifies the following⁴:
 - > the diagnosis and any co-existing mental health conditions
 - > short-term goals for treatment
 - > long-term goals for treatment
 - > situations that trigger distress or increase risk

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- > self-management strategies that reduce stress and risk
 - > strategies that have been used in the past with the aim of reducing distress, but were not helpful or made things worse
 - > who to contact in an emergency
 - > health professionals, services and agencies involved in the person's treatment and their roles including past involvement with FamiliesSA
 - > all other people helping with the person's treatment (e.g. family, partner, carers or friends), including their role in supporting the person
 - > the planned review date
 - > who has a copy of the plan (list people and services)
- > Aim for continuity of care and carer and where possible, team discussions to ensure common goals and to avoid tensions between team members which can arise when women with this personality disorder become very dysregulated in their behaviour or emotional state.
 - > Consider obstetric consultant and psychiatric review
 - > Identification of symptom patterns as described above will lead to consideration of a team approach for and with the woman and her family
 - > Better treatments (see below) are now emerging for BPD and community treatment referral may be acceptable to the woman in addition to a considered plan for management of her pregnancy. Whilst not universally available, dialectal behaviour therapy groups can sometimes be accessed

Perinatal management

- > The fetus / infant needs to be central to the considerations of treatment, as the relationship between an infant and his / her mother or other caregiver is critical for development: early identification of features of BPD is critical⁵.
- > Diagnosis by an appropriate mental health practitioner who can provide the woman and her family with information about the diagnosis and some treatment options may be useful and many but not all women appreciate this approach. Ensure that family and others involved in their care understand the treatment plan and aims
- > People with BPD should be offered access to structured psychological therapies that are specifically designed for BPD and conducted by one or more adequately trained and supervised health professionals⁴. Community treatment teams and private psychologists or private psychiatrists may provide these treatments
- > The deficit in regulating emotions and managing stress may pose a significant risk to the infant² (follow link to 'Intent to harm fetus' in the A to Z index at www.sahealth.sa.gov.au/perinatal) as do issues of self-harm (follow link to 'Suicidal ideation and self-harm' in the A to Z index at www.sahealth.sa.gov.au/perinatal)
- > Medication, while of some benefit for temporary relief or stabilisation of mood, is not the mainstay of treatment and guidelines from the Australian Government clarify this further⁸. Psychotropic medications used in pregnancy have risks for mother and for fetus (follow link to 'psychotropic medication during pregnancy and breastfeeding: A guide to guidelines' in the A to Z index at www.sahealth.sa.gov.au/perinatal)

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Factors to consider

- > Consistency and continuity in approach, validating the woman's distress and then helping with basic problem-solving techniques, and assistance in managing psychological distress form the foundation for the clinical approach to these women
- > Be mindful of the possibility of overdose and other self harm in this group of women⁶ (follow link to 'Suicidal ideation and self-harm' in the A to Z index at www.sahealth.sa.gov.au/perinatal)
- > Requests / demands for early delivery may dominate the presentations and a team approach as outlined above is likely to be beneficial
- > The practitioner needs to be very clear about his / her role and boundaries
- > Often a case conference with all agencies and workers involved is a useful initiative. These can also assist by identifying the 'lead' worker, both in the hospital setting and in the community
- > Establish a clear protocol for how all members of the team will respond to the woman during a crisis. Crisis contacts should be brief, focused and goal-oriented. If possible, give the woman some responsibility for resolving the crisis. Women with a diagnosis of BPD are likely to present with co-morbid mental illness. People with BPD who also meet diagnostic criteria for a substance use disorder, anxiety disorder, mood disorder or eating disorder should be referred to services which offer concurrent management of both conditions
- > Women with BPD can arouse strong emotions in the people caring for them and can also cause tensions between treating practitioners / teams because of their own high levels of distress and (at times) troubled and troubling behaviours. Emotional responses can then influence clinical decision making. Regular team discussions and reviews can be helpful as can supervision and the involvement of perinatal mental health teams
- > Focus on immediate, everyday problems. The aim is not to cure the personality disorder but to help the woman deal with everyday life. Behavioural disturbances associated with personality disorder tend to improve with advancing age
- > Specialist treatment of personality disorders consists of a combination of psychological treatments reinforced occasionally by drug therapy if there are co-morbid features. Psychological treatments include dialectical behaviour therapy (DBT) and mentalisation based therapy (MBT). These are available in some areas through adult mental health services and private psychologists or private psychiatrists
- > **Aboriginal people often become lonely, disconnected and distrustful when they are separated from their families and country. Consult with the aboriginal health professional**



Postpartum

Collaboration between midwives and perinatal mental health services

- > On-going risk assessment
- > Maintain clear communication, collaboration between all levels of staff
 - > Early referral where risk identified to either mother or infant
 - > Documented plan of care which could include a baby care plan. Information regarding what to do if the mother is in crisis can be found on www.copmi.net.au
- > Parents with BPD should be considered a high priority for referral postnatally to early childhood intervention services
- > Mothers with BPD and their infants might show disturbed patterns of interaction, compared with mothers and infants in the general community, and mothers with BPD experience specific parenting issues⁴. There is also emerging evidence that severe mental illness in a parent may increase an infant's risk of multiple mental and developmental problems⁴

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Follow-up

- > Patients with a diagnosis of personality disorder can be supported by a primary care team in conjunction with input from specialist psychiatric services where appropriate. Often these patients fare better in a community setting with a skill based and well-being approach rather than a medical or pathologising approach. The support generally needs to be long-term and the style of consultation needs to be adapted to the type of personality disorder and presenting features. More information is available from the NHMRC Clinical Practice Guidelines⁸



- > ***Aboriginal women should be consulted on any follow up plans and supported by their nominated aboriginal health professional***

Acknowledgement: NHS Evidence, WHO UK collaborating centre

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References

1. National Institute for Mental Health in England (NIMHE). Personality Disorder: No Longer a Diagnosis of Exclusion. Policy Implementation Guidance for the Development of Services for People with Personality Disorder. Leeds: Department of Health; 2003. Available from URL: <http://www.nimh.nih.gov/health/publications/borderline-personality-disorder/index.shtml>
2. Newman L, Stevenson C. Parenting and borderline personality disorder: Ghosts in the nursery. *Clinical Child Psychology and Psychiatry* 2005; 10: 385-390.
3. Hughes AE, Crowell SE, Uyeji L, Coan JA. A developmental neuroscience of borderline pathology: emotion dysregulation and social baseline theory. *J Abnorm Psychol* 2012; 40: 21-33.
4. American Psychiatric Association (APA). Diagnostic and statistical manual of mental Disorders. 4th ed. Washington: American Psychiatric Press; 1994.
5. Blankley G, Galbally M, Snellen M, Power J, Lewis A. Borderline personality disorder in the Perinatal period: Early infant and maternal outcomes. *Australasian Psychiatry* (in press) 2015.
6. British Columbia Reproductive Care Program. Reproductive mental health guideline 3: Identification and assessment of reproductive mental illness during the preconception and perinatal periods. Vancouver: Perinatal Services BC; 2003. Available from URL: <http://www.perinataleservicesbc.ca/>
7. National Institute for Health and Clinical Excellence (NICE). Borderline personality disorder: treatment and management. NICE clinical guideline 78. London: National Collaborating Centre for Mental Health; 2009. Available from URL: <http://www.nice.org.uk/nicemedia/live/12125/42900/42900.pdf>
8. National Health and Medical Research Council. Clinical practice guideline for the management of borderline personality disorder. Melbourne: National Health and Medical Research Council; 2012. Available from URL: <http://www.nhmrc.gov.au>
9. Winston AP. Recent developments in borderline personality disorder. *Advances in Psychiatric treatment* 2000; 6: 211-18. Available from URL: <http://apt.rcpsych.org/cgi/content/full/6/3/211>
10. Stepp SD, Pilkonis PA, Hipwell AE, Levine MD. Children of mothers with borderline personality disorder: Identifying parenting behaviors as potential targets for intervention. *Personality disorders: Theory, research and treatment* 2012; 3:76-91

Useful web sites

University of Adelaide. Treatment guidelines for Mental Health. Available from URL: <http://www.adelaide.edu.au/library/guide/med/menthealth/guidelines.html#postpartum>

Borderline personality disorder information and support website. This site is mainly for families of people with Borderline personality disorder. Available from URL: <http://www.BPDcentral.com>

'Borderline UK' and 'Personality Plus' have merged to become 'Emergence'. A national service user-led organisation with the overarching aim of supporting all people affected by personality disorder including service users, carers, family & friends and professionals. The site provides detailed information on Borderline personality disorder. Available from URL: <http://www.emergenceplus.org.uk/>

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Abbreviations

APA	American Psychiatric Association
BC	British Columbia
BPD	Borderline personality disorder
DBT	Dialectical behaviour therapy
EPDS	Edinburgh Postnatal Depression Scale
GP	General Practitioner
MBT	Mentalisation based therapy (treatment)
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NIMHE	National Institute for Mental Health in England
UK	United Kingdom
URL	Uniform Resource Locator
WHO	World Health Organisation

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