CLINICAL PSYCHOLOGY
SCIENCE AND PRACTICE

Mothers With Borderline Personality Disorder: Transition to Parenthood, Parent–Infant Interaction, and Preventive/Therapeutic Approach

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Borderline personality disorder (BPD) is among the most severe and perplexing mental disorders. Adults with BPD appear particularly exposed to severe difficulties in the transition to parenthood, infant caregiving, and the establishment of healthy early interactions. Studies on the offspring of parents with BPD show a high prevalence of social and emotional symptoms, including BPD features. This article reviews the possible consequences of this mental disorder for women during the transition to parenthood, for the quality of early mother–infant relationships, and for infant development. A presentation of a clinical case illustrates these issues, and some features of the preventive/therapeutic approach of these dyads are discussed.

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Key words: **borderline personality disorder, development, early interaction, infant, mother, parenthood.** ***[Clin Psychol Sci Prac 21: 139–153, 2014]***

Perinatal and infant psychologists and psychiatrists are often faced with complex clinical situations in which unresolved traumatic events emerge from the parent's past in an abrupt way, which hampers the transition to parenthood. Some of these parents, in particular women, meet the criteria for borderline personality disorder (BPD). BPD, which is characterized by persistent and pervasive cognitive, emotional, and behavioral dysregulation, is among the most severe and perplexing mental disorders. The BPD phenotype is broadly defined by emotion dysregulation (range, intensity, lability, and appropriateness of emotional response), cognitive disturbance (self-image, perception of others and of events), poor impulse control, identity disturbance, problematic interpersonal relationships, and suicidal or self-injurious behaviors, among other features (American Psychiatric Association, 2000). Borderline patients may also show transitory episodes of paranoid and dissociation symptoms. In addition,

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BPD has a high comorbidity with other psychiatric illnesses, in particular affective disorders, posttraumatic stress disorder, and substance abuse (Barnow, Spitzer, Grabe, Kessler, & Freyberger, 2006; Farmer & Nelson-Gray, 1990).

The therapeutic management of parents with BPD is described as arduous and challenging (Aidane, Wendland, Rabain, & Marie, 2009). Levy (2005) has observed that this population is characterized by "high rates and chaotic use of medical and psychiatric services, repeated patterns of dropout, erratic psychotherapy attendance, refusal to take prescribed medications, and pervasive noncompliance" (p. 960). As the transition to parenthood is known as a period of higher psychological vulnerability, parents with BPD are likely to seek psychological support in perinatal mental health services. The unstable and fragile features of their personality expose borderline women to severe difficulties in the transition to parenthood, in infant caregiving, and in the establishment of healthy early interactions. Having a child may in fact lead some of these parents to have their first contact with mental health services. In the authors' outpatient parent–infant mental health unit, at least half the parents had never received any kind of treatment until the birth of their first child.

Unlike the extensive literature on the offspring of mothers with other psychiatric disorders such as depression and anxiety disorders, or on adults with BPD, only a few studies have been conducted with children whose mothers have been diagnosed with BPD. Most studies on this population focus on school-aged children and adolescents. Many family and genetic studies are limited in scope, as they focus on the family of origin rather than on the offspring of patients with BPD. In a recent review of the literature, Macfie (2009) confirmed this gap: "It is unusual in the field of child development to find almost totally uncharted territory" (p. 69). However, the high prevalence of social and emotional troubles observed in children and adolescents raised by borderline mothers may be partially ascribable to early disturbances in the parent–child relationship. Parents suffering from BPD may represent a major concern for public health (Stepp, Whalen, Pilkonis, Hipwell, & Levine, 2011). This highlights the need for early intervention and prevention strategies targeted at this population.

This article reviews the consequences of this mental disorder on women during the transition to parenthood, as well as on the establishment of early mother–infant relationship and on infant development. A presentation of a clinical case allows us then to illustrate these issues and to discuss some features of the preventive/therapeutic approach employed with these dyads.

WHEN BORDERLINE WOMEN BECOME MOTHERS: THE TRANSITION TO PARENTHOOD

The perinatal period is characterized by considerable personal, marital, and social upheavals (Stern, 1995). Although parenthood is generally viewed as a growth period and as an opportunity for positive change, women with BPD, given their pervasive psychological difficulties, will likely experience severe difficulties in the transition to parenthood. There is very limited empirical data on this topic, and most available literature (cited in this section) is based on clinical cases.

For some women with BPD, the pregnancy period may be experienced as an idyllic and highly idealized moment, with euphoric feelings of plenitude and omnipotence, and of having full control over the future child (Le Nestour, 2004). In other cases, the physical symptoms of pregnancy may be very intense and experienced as unbearable (fears of bursting, feelings of persecution and strangeness) or, conversely, may be completely ignored (Aidane et al., 2009). Attendance to prenatal care is often irregular. As a result, the mother may be poorly prepared to welcome her baby at birth.

These women may also be subject to serious mood disturbances during the perinatal period, in particular to major depression, which in some cases may have a complex clinical phenotype (Apter-Danon & Candilis-Huisman, 2005). Episodes of self-harm, suicidal behaviors, or addiction may also take place in this period (Newman & Stevenson, 2008).

Clinical reports show that while the infant may have been strongly idealized during pregnancy and expected to repair the lacks of his mother's past and present life, after birth, the baby is naturally unable to fulfill his mother's needs (Aidane et al., 2009). Actually, the baby rather takes his mother back to her own childhood and mirrors her own infantile distress, dependence, and fear of abandonment (Le Nestour, 2004).

Despite their desire to have a child, mothers with BPD may feel estranged, overwhelmed, and/or angry with their infants as early as birth (Newman, Stevenson, Bergman, & Boyce, 2007). These mothers seem to be caught between their desire to be a good mother and to give adequate care to their baby, and their own affective needs, which often exclude or postpone the child's (Aidane et al., 2009).

The psychological tasks of parenting, which involve consistent and empathic care, attachment security promotion, physical proximity, tolerance of dependency, and frustration of their own needs, are particularly demanding for adults with BPD. In this respect, these women may show in the first months postpartum a state of intense and chronic fatigue and irritability and find it difficult to establish steady rhythms in the infant's daily care (Aidane et al., 2009). These new mothers may feel less satisfied, less competent, and more distressed in their maternal role than mothers in the general population (Newman et al., 2007).

IMPACT ON INFANT AND CHILD DEVELOPMENT

Little empirical attention has been given to offspring outcomes in the context of maternal BPD, in particular for infants and young children. To our knowledge, there is no prospective study on children of mothers with BPD beginning from birth or early infancy.

Retrospective studies on childhood and family characteristics show that individuals diagnosed with BPD are very likely to have suffered from dysfunctional, neglectful, or abusive (sexual or emotional) relationships with their parents, including incest, maltreatment, domestic violence, and early loss (Beziganian, Cohen, & Brook, 1993; Rogosch & Cicchetti, 2005). Children diagnosed with borderline traits are more likely than control children to describe their parents as unaffectionate, aggressive, neglectful, controlling, and rejecting (Lefèbvre, Howe, & Guilé, 2004). Compared to control children reared by mothers with no psychiatric diagnosis, children and adolescents whose mothers have BPD meet significantly more criteria for psychiatric diagnoses, in particular BPD itself or borderline traits (Weiss et al., 1996), and are more likely to display attention and behavior disorders, depression and anxiety symptoms, and suicidal thoughts or attempts (Barnow et al., 2006; Danti, Adams, & Morrison, 1985). A 10-year longitudinal study showed that when inconsistent and inappropriate parental behavior and maternal overinvolvement coexist, there are higher risks for the child to develop personality disorders such as BPD (Beziganian et al., 1993).

Macfie and Swan (2009) reported that children aged 4–7 years whose mothers have BPD, compared to control ones, told stories with the following: (a) more parent–child role reversal, more fear of abandonment, and more negative mother–child and father–child relationship expectations; (b) more incongruent and shameful representations of the self; and (c) poorer emotion regulation indicated by more confusion of boundaries between fantasy and reality and between self and fantasy, more fantasy proneness, less narrative coherence, and marginally more intrusion of traumatic themes.

Adults with BPD have limited capacities to empathize with others, may feel overwhelmed by their heightened sensitivity, and have severe difficulties in dealing with interpersonal relationships (Putnam & Silk, 2005). Kernberg (1967) has also noted that they tend to have a hostile, paranoid worldview that leads them to be suspicious of the intent of others. This may reflect a failure to reach a key developmental milestone in childhood: acquiring the ability to recognize that others may have different intents and perspectives than oneself. Because the transition to parenthood does not significantly modify their psychological functioning, when adults with BPD become parents, these distortions may have a major impact on parent–infant interactions and consequently on infant development as well.

Stepp et al. (2011) posited that persistent and huge inconsistencies in parenting strategies may be in fact the key feature that differentiates parents with BPD from parents with other forms of psychopathology (i.e., major depression or anxiety disorders). However, more research is needed to distinguish parents with BPD from those affected by other mental disorders. Infants of mothers with BPD may be exposed to high levels of discontinuity and unpredictability in daily care. The mother's responses to the infant's needs may be paradoxical, unexpected, and frightening, even to an adult who observes the interaction (Aidane et al., 2009). The mother may put her own personal needs ahead of her infant's or react to her own needs to infer those of the

child (e.g., the infant may be fed or put to bed when the mother herself feels hungry or sleepy; Aidane et al., 2009). Even in the absence of overtly violent behavior, the infant can be confronted with a lack of attention to his most basic physiological and emotional needs, sometimes going as far as a denial of his individuality and subjectivity by the adult (Mazet, Rabain, Downing, & Wendland, 2002). These mothers may also misinterpret or avoid the infant's bids for interaction (Newman et al., 2007) and find it difficult to establish any kind of communication insofar as the infant is unable to speak.

These behaviors may hamper important parental tasks, such as emotional validation, autonomy scaffolding, and monitoring practices. On the infant's part, these distortions may impact his aptitude to understand his own feelings and those of others and to form steady, predictable, and secure relationships. As a result, mother and infant may be thwarted in their efforts to engage positively, and both are likely to get disappointed and to withdraw from interaction (Apter-Danon & Candilis-Huisman, 2005).

Whether prospective or retrospective, the results from available studies converge around the notion that individuals who develop BPD have suffered from early, long-lasting, and severe distortions in their relationship to their caregivers, in particular their mothers. However, studies on early mother–infant interaction involving mothers with BPD have only begun in the last decade.

EARLY INTERACTIONS OF MOTHERS WITH BPD AND THEIR INFANTS

To date, only a few studies have described the characteristics of early interactions between mothers with BPD and their infants. Clinical observations have shown a composite maternal interactive style made of an unpredictable alternation of forced interaction, intrusion, and withdrawal (Aidane et al., 2009; Apter-Danon & Candilis-Huisman, 2005; Newman & Stevenson, 2005). The infant may react by sustained withdrawal and apparent calm, rather than by "noisy" symptoms such as crying or restlessness (Wendland & Medeiros, 2010; Wendland et al., 2010). Maternal discontinuity probably pushes the baby to develop self-protective strategies, such as inhibiting the expression of his needs, sometimes going as far as freezing behaviors (Fraiberg, 1982).

In a study using the *still face* paradigm (Tronick, Als, Adamson, Wise, & Brazelton, 1978), mothers with BPD were described as being less sensitive and more intrusive when interacting with their 2-month-old babies compared to nonclinical controls (Crandell, Patrick, & Hobson, 2003). In turn, their infants showed less positive affect during and after the *still face* procedure, looked away from mothers more often, and were more likely to display a dazed look (including freezing of facial movements). Similar findings were found by Hobson, Patrick, Crandell, Garcia-Perez, and Lee (2005) with BPD mothers and their 1-year-old infants. When distressed, following a brief separation from their mother during the *strange situation*, infants of borderline mothers displayed simultaneous contradictory behaviors and seemed caught between a desire to approach the parent and a fear of doing so, which is a typical pattern of disorganized attachment behavior. Interestingly, very similar interactive patterns to those observed in a structured situation such as the *still face* were found in a free-play session (Newman et al., 2007). Mothers with BPD were found to be less sensitive, more intrusive, and more inconsistent in their interactive behaviors. They also demonstrated less structuring in their interactions. In turn, their infants paid less attention to their mothers and seemed less interested in interacting with them.

In one of the first theoretical models of BPD, Masterson and Rinsley (1975) put forward that borderline patients had not successfully achieved the separation-individuation process (Mahler, Pine, & Bergman, 1975). Mothers with BPD may in fact show overinvolvement with their child and subsequent withdrawal of love upon the child's attempts to separate, sometimes encouraging regressive behavior and thereby leading to poor individuation in the child (Danti et al., 1985; Macfie, 2009; Masterson, 1976). Separation experiences may be viewed as threatening for their maternal sense of identity and self-confidence (Aidane et al., 2009).

In line with these ideas, attachment theory is understood to be a meaningful and almost indispensable way to approach people with BPD and their interpersonal relationships (Barone, Fossati, & Guiducci, 2011). As

mentioned above, there is considerable evidence to suggest that the development of BPD is associated with negative experiences with attachment figures in early childhood (Buchheim & George, 2011), in particular with early attachment trauma. Research has shown a robust link between BPD and attachment disturbance in adults, in particular with unresolved attachment, which is a representational form of disorganized attachment in adulthood (Barone, 2003; Levy, 2005; Lyons-Ruth, Yellin, Melnick, & Atwood, 2005). Conversely, secure attachment is rare among BPD adults (Levy, 2005).

Unresolved loss and trauma, as well as child maltreatment by primary caregivers, have also been reliably linked with disorganized attachment in children (Solomon & George, 1999). If young children consistently fear their primary caregiver, or when the caregiver herself appears afraid or abdicates the protective function of caregiving, children experience helplessness and disorientation. When the effects of these experiences persist up to adulthood, they are thought to increase the risk of BPD (Crittenden & Newman, 2010; Fonagy, Gergely, Jurist, & Target, 2002; Holmes, 2004; Salzman, Salzman, & Wolfson, 1997). In this case, the adult who becomes a parent is at risk of reenacting these severe distortions of interaction with his or her own children, in particular displaying atypical parental behaviors (e.g., frightened-frightening, helpless and dissociated behaviors; Fonagy, Target, & Gergely, 2000; Goldberg, Benoit, Blokland, & Madigan, 2003; Hobson et al., 2009; Madigan et al., 2006; Schuengel, Bakermans-Kranenburg, & Van Ijzendoorn, 1999). Hence, the attachment model illustrates one of the pathways for the potential intergenerational transmission of BPD (Solomon & George, 2006), which is a key point for a preventive and therapeutic approach. As suggested by Crandell, Fitzgerald, and Whipple (1997), insofar as the mother has a defensive or entangled state of mind regarding attachment, she may either intrude upon or dismiss affective experiences that arise in the context of mother–infant interaction and thereby affect the infant's ability to integrate and regulate emotions, which predisposes the infant to later psychopathology.

To summarize, interactions of mothers with BPD with their infants seem to be characterized by intrusive, insensitive, and disrupted behaviors on the mother's part, while their infants are prone to display various patterns of withdrawal or disorganized behaviors, which in turn may predispose them to develop attachment disorders or later psychopathology.

CLINICAL CASE

Bearing in mind the clinical and empirical evidence described above, assuming a preventive approach emerges as the most suitable way to help adults with BPD in their transition to parenthood and to prevent the consequences of this mental disorder on their offspring. This assumption supposes that we should work from the very beginning of infancy and at the heart of parent–infant/child relationship, that is, in a joint and as early as possible intervention, rather than treating the parent and/or the child separately, or only when symptoms become visible in the child.

To illustrate the issues described above, we report the clinical case of Mrs. D. (diagnosed with BPD by two psychiatrists on the basis of *DSM-IV* [American Psychiatric Association, 2000] criteria) and her young daughter. The dyad was followed from pregnancy to the infant's third birthday in a public parent–infant mental health unit. To warrant confidentiality, data have been to some extent modified or omitted.

Mrs. D. is a single mother, 34 years old, who consulted the unit when she was 6 months pregnant. She found our address on the information board of the maternity prenatal ward and decided to consult of her own volition.

During the first consultation, Mrs. D. said she was afraid of repeating the physical and psychological abuse she had experienced with her mother when she was a child. She was her parents' only child. Like many BPD patients, she described the relationship with her parents, both present and past, as very disturbed and frustrating. She had a conflicting relationship with her mother, against whom she had feelings of hate and revenge. She even made fun of her mother's cancer, which was in its terminal stage. The relationship with her father was marked by a notable depreciation of his role and a feeling of neglect. She said about her father: "He never cared about what happened to me," "he did not act as a father," "he is stupid, an idiot." While the relationship to the father appeared as distant, her

words regarding her mother expressed rather more conflict: "My mother beat me," "I was supposed to make her dreams come true," "I hate her, she is a bad person." It was as if she had never known a good enough model of parenthood in her family. Mrs. D. had damaged skin and hair and appeared older than her actual age. She had had a disrupted life trajectory: maltreatment, sexual abuse, episodes of prostitution, drug addiction, a problematical schooling, and no professional status. She frequently changed jobs. She was proud to report that she had recently swindled people by selling them fake goods. As a child, she sometimes behaved violently against animals. Later during the treatment, she also revealed that she had suffered from transitory episodes of anorexia nervosa and bulimia. As mentioned above, BPD is often comorbid with other symptoms or diagnoses, and this was probably the case for Mrs. D. in some periods of her past (i.e., transitory eating disorder, drug addiction) and present life (i.e., traits of antisocial personality disorder, brief depressive episodes; Barnow et al., 2006; Farmer & Nelson-Gray, 1990). When Mrs. D. announced her pregnancy to the infant's father, they were already separated. The father was a man she had met in one of the several churches, prayer, and self-help groups she attended. Their relationship was brief and unsteady.

The Prenatal Period

During the prenatal period, Mrs. D. was seen very regularly (at least once a week) by an infant psychiatrist of our unit. During these consultations, in a discourse marked by logorrhea and confusion, Mrs. D. reported her personal history and in particular her fear of repeating with her daughter the verbal and physical violence she had endured in her own childhood. She had a normal pregnancy, which was actually her third one. She said she had decided not to terminate this pregnancy, unlike the others, because she feared she might not be able to get pregnant again.

The Postnatal Period: From Birth to the First Semester

Delivery was normal, with no medical complications for the mother or the baby. The child was a baby girl who was named Allegra by her mother. A few months later, during a psychotherapy session, Mrs. D. said that she had not done her daughter a favor by naming her Allegra, which means "happy/joyful," adding, "it's a heavy load to carry."

Soon after the baby's birth, the mother was overwhelmed by her new situation and showed little empathy toward her baby's needs and signals. She almost did not speak about her baby, speaking rather of herself. She spoke without restraint and elaboration, and her emotions were rough and dissonant. Mrs. D. could not respect her child's rhythms and needs, which she felt to be too intrusive and demanding. Allegra was fed, diapered, and put to bed according to the mother's own time schedule and emotional state. Early interactions between Allegra and her mother were characterized by intrusiveness, overstimulation, unpredictability, low sensitivity toward the infant's signals, and contradictory responses to the infant's needs (i.e., speaking loud and waking up the baby to play with her, or forgetting feeding time and putting a hungry baby to bed). Mrs. D. also showed some disrupted and frightening behaviors (Madigan et al., 2006), such as picking up the baby in a sudden and unsafe way, suddenly changing voice tone, or laughing while the infant was crying.

At the time, Mrs. D. said she was unable to give her child what she herself had not received: It would have been "too unfair" for her daughter to have the love she was still waiting to receive from her parents. Mrs. D. presented herself as a neglected child, unable to assume the role of an "adult mother." She said she did not have any motherly feelings for her baby girl. However, she did expect love and attention from her daughter. Interactions were actually marked by some rivalry and role reversal: Mrs. D. sometimes behaved as a little child or as Allegra's sister, showing jealousy toward the attention or the toys received by the child from other people; in other moments, the mother expected her daughter to keep her company when she was sick; the infant was then put to bed very late at night.

Given this worrying situation, the mother and the child were seen several times a week by an infant psychiatrist and a pediatric nurse, and the dyad participated in a parent–infant guidance group once a week. In our unit, pediatric nurses provide parents with nursing and parental guidance on infant needs and daily care, including feeding, hygiene, sleep, clothing, play,

and health issues. If necessary, infant feeding and bathing may be scheduled at the unit, in the presence of the pediatric nurse, who provides the parent with practical assistance, guidance, and reassurance. In some critical periods (as in the situation under discussion), sessions may be scheduled more frequently (even daily) and/or prolonged, and parents can spend several hours in the unit (there are some quiet rooms where the parents and the infants may have a rest and where meals can be prepared). Mrs. D. spent several hours per week in the unit and talked very often with the pediatric nurse about the infant's sleep and feeding schedule and other basic needs. The pediatric nurse also provided the mother with psychoeducation on child developmental milestones. Sometimes she asked some surprising questions, such as "She makes sounds. Why? The babbling, does it come from the vocal chords?" or "Why does she look at me, do I exist for her?" These questions revealed the difficulty Mrs. D. had of representing her daughter's experience and the mismatch of early intersubjectivity experiences (Stern, 1985).

For some BPD mothers, the maternal role is beyond representation, and we can hear these mothers saying, "I don't know how to be a mother." This was clearly the case of Mrs. D. BPD mothers seem to be continuously seeking solutions to day-to-day parenting issues (Newman & Stevenson, 2008) and may focus all their attention on physical complaints and daily hassles. There are usually low levels of pleasure in daily life, and the infant may be perceived only through his or her demands or physical symptoms. The feeling of being a "bad" mother is not rare. Therefore, all interventions should be nonjudgmental and aimed at promoting the parent's capacity to engage in empathetically and emotionally responsive interaction with the infant, thereby reinforcing parental self-confidence.

During the first months of the postpartum period, Mrs. D. agreed to come to the unit several times a week to see the infant psychiatrist and the pediatric nurse. However, she refused to engage in mother–infant psychotherapy. From the age of 2 months, in reaction to her mother's inadequate and insensitive behavior, Allegra showed signs of early sustained withdrawal, which lasted about 2 months. She seemed without vitality, was pale, and responded weakly to the stimuli from adults. At that period, the mother sometimes held her daughter in a very awkward way, which required the prompt intervention of the pediatric nurse to prevent Allegra from falling. However, at the same time, the mother had difficulty putting the baby down on the carpet and giving her the opportunity to explore.

Mrs. D. also spoke about her ambivalent feelings toward Allegra: "I sometimes tell her to shut up, but she is still a baby, and yet she is a part of me, but I can't help it." Although she loved her baby, Mrs. D. said she did not feel attached to her and that she could easily leave her with other adults. She justified this behavior by saying, "I don't want to be too close to her, I was almost suffocated by the proximity of my mother." As discussed above, Mrs. D. had difficulty finding the suitable distance with Allegra and oscillated between being too close and being too distant (Newman & Stevenson, 2005).

It is interesting to note that, at this period, the unit team discussed the necessity of separating this child from her mother on several occasions. However, signs of enhancement of the mother's sensitivity and better mother–infant interactions became progressively visible. Besides, contrary to many BPD patients, Mrs. D. attended all appointments, showed cooperative behavior, and was grateful to the team. When Allegra was 6 months old, Mrs. D. also agreed to leave her 5 days and 2 nights per week to a professional nanny, as a child protection measure and as a way to give the caregiver some relief.

The Second Semester of the Infant's First Year

During the second semester of the infant's first year, Allegra and her mother were still seen very often by the infant psychiatrist and the pediatric nurse. Mrs. D. was told not to continue with the parent–infant group, even though she said she could find some relief in it. It has indeed been noted that, given their problematic interpersonal relationships, parents with BPD generally do not adapt to this kind of setting very well. On the one hand, Mrs. D. had an important need to speak about herself and tended to monopolize speaking time. She also could engage in tense verbal exchanges and make disparaging comments about other parents and infants. On the other hand, and this was the main rationale for changing treatment, the team concluded

that parent–infant group did not offer the opportunity to achieve the in-depth and intensive psychotherapeutic work that was needed in this case. The infant psychiatrist therefore suggested that she might begin a course of mother–infant psychotherapy with a clinical psychologist and psychotherapist. Allegra was then 8 months and, at that time, the mother agreed to it.

From the beginning, the psychotherapist was faced with several complex difficulties. Mrs. D. had a disconnected and logorrheic speech pattern. Speech and affects were unmatched and appeared inauthentic. Mrs. D. seemed to behave by overflow: When she was overwhelmed, she might react abruptly and become aggressive. Slight aggressive acting-out on Allegra was frequent. She spoke about her daughter in rather depreciative terms and seemed to experience no pleasure in interacting with her. Mrs. D. seemed unable to provide a coherent narrative of her past; she only had a few memories of her childhood and her adolescence and reported them without affect. She showed a poor capacity for introspection and insight. The psychotherapist had difficulty remembering the course of the sessions and even writing notes after the appointments.

Indeed, clinical work with these patients may engender countertransference feelings of emptiness, discontinuity, and inconsistency, which might reflect to some degree the devastating impact of their traumatic past (Aidane et al., 2009). The therapist may feel invaded by feelings of being ineffective, disqualified, and useless. The clinical setting then requires substantial adaptation to cope with the mother's characteristics, which include a mentalization deficit, sudden mood swings, aggressive words or behaviors directed to the therapist or the infant, as well as difficulties in complying with the scheduled setting (day/time of sessions). These difficulties are linked not only to their instability, impulsiveness, and fear of abandonment, but also to their rigid and fragile defensive mechanisms, such as denial, splitting, and idealization (Kernberg, 1984).

According to Cramer and Palacio-Espasa (1993), these features are linked to an unfavorable prognosis for mother–infant joint work. Given this context, the psychotherapist was doubtful about the true therapeutic possibilities of this therapy. However, Mrs. D. seemed cooperative with the team, and she stated several times that she did not want to repeat her disrupted past with her daughter. At this point, it is important to underscore that in our unit, the therapeutic approach does not pointedly target the mother's mental disorder. This would neglect the new and specific parental and infant needs. Thus, we only address mother–infant relationships, infant development, and parenting issues. The most important point is to keep in mind the baby, who is at the center of the treatment. Fundamentally, we consider that the patient is both the actual baby and the "child" who still lives inside the mother. The joint psychotherapy of Mrs. D. and her daughter became possible for the psychotherapist when she limited herself to the mother–child relationship and when she recognized that Mrs. D. was indeed a mother, trying not to repeat her traumatic past. The therapist no longer focused on looking for a change in the mother's mental functioning.

In parallel, Mrs. D. and her daughter met the pediatric nurse and the infant psychiatrist regularly, as well as the social worker, which ensured a stable and solid setting made up of several professionals. When working with a BPD mother, the mother's own narcissistic needs are often put to the fore and any attention paid to the baby may generate intense rivalry and result in treatment dropout. Thus, we believe that only a shared therapeutic approach, including two or more practitioners, allows them to take into account both the parental and the infant's needs for care. Each practitioner, with his or her professional status and specific intervention, can serve as a support for both the mother's and the infant's needs. In this setting, mothers sometimes display projective representations, splitting practitioners into good and bad interchangeably. These complex movements need to be integrated and elaborated by the practitioners during regular team discussions, sometimes under external supervision.

In our unit, parent–infant psychotherapy is psychoanalytically grounded and may include video feedback (described later; Beebe, 2003; Cramer & Palacio-Espasa, 1993; Jones, 2006). More specifically, the therapy of Mrs. D. and her daughter was based on the principles formulated by Selma Fraiberg and her colleagues (Fraiberg, Adelson, & Shapiro, 1975). Treatment techniques are also partially inspired from Kernberg's (1984) and Bateman and Fonagy's (2004) approaches, whose primary aim is to develop the

adult BPD patient's capabilities of self-observation, introspection, and mentalization (reflective functioning). Another foremost therapeutic approach applied to this population, dialectical behavior therapy (Linehan, 1993), is also likely to help new mothers with this mental disorder, but members of our team are not trained to use this approach. To our knowledge, there is no documented use of this approach with parents experiencing the perinatal period.

As in all therapeutic settings, the first goal was to build and to maintain a work alliance with Mrs. D. and her daughter, in spite of the features described above. Thanks to this "secure basis," the patient is generally able to explore her internal world and the painful contents of her past and present life. However, feelings of security and confidence are usually rare in BPD patients. They are distrustful and resistant, and it appears difficult for them to share an emotional experience with a psychotherapist. Therefore, to begin with, rather than working from the mother's side, the therapist focused her attention on Allegra's experiences, initiatives, and responses to her mother. In other words, the parent and the therapist looked at the baby together. Only during the second year of Allegra's life was the psychotherapist able to help the mother think about past and present representations and their links with the current parent–infant relationship (Cramer & Palacio-Espasa, 1993). This work included chasing out the "ghosts in the nursery" that might hamper infant development and the transition to parenthood through relationship distortions (Fraiberg et al., 1975). However, as recommended by Kernberg (1984), interpretation was used with caution and very progressively, as a form of "guided discovery" so as to increase the patient's feeling of responsibility and control.

Given the present circumstances, the use of video recording and video feedback was very useful. Mrs. D. agreed to be filmed with her daughter at least once a month, and most of the time she appreciated the video feedback sessions. Video feedback can help create a triangular space in which the mother is invited to observe herself in interaction with her infant (Beebe, 2003; Jones, 2006). This can lead to the parent being able to recognize that the baby has a point of view that is different from the parent's. The parent is invited to get down on the floor, follow her child's lead, and engage in mutual and attuned interactions with the infant. Video feedback can also improve the parent's ability to remember and reflect upon past influences that may be contaminating the relationship with the child at present. The images, as "concrete" material, may serve as a medium for mental representations. This technique also enables the therapist to reinforce parental self-confidence, as she sheds light on some positive aspects of the parent's behavior. During and after the viewing of the video, the therapist asks the parent to say how she feels and say whatever comes to mind, namely, to free associate. In order for such spontaneity to occur, there needs to be a strong, trusting relationship between the therapist and the parent. The therapist pays attention to the parent's verbal and nonverbal language, to the associative process while watching the video, and to what it leads to thereafter in the therapy session.

As an illustration of this work, a video clip of Allegra and her mother at 10 months shows how frustrating and incoherent the mother–infant interactions are. After suggesting a dolls' tea party, Mrs. D. pretends to feed her daughter with a spoon, but as soon as Allegra responds by opening her mouth, the mother laughs and tells her it is not time to eat. Allegra is then obviously frustrated and gets angry. She cannot understand her mother's attitude. The mother puts her daughter in a position of ridicule. The mother said this was just for fun. But, after viewing the video, she said, "this was not a good joke," and she spoke about how frustrated and betrayed she had felt when her mother humiliated her during her childhood. Mrs. D. realized she often laughed when her daughter was in a situation of distress or when her expectations were frustrated, for example, when she had to wait for her bottle, when Mrs. D. removed the toys from her hands and offered her inadequate or too difficult activities, or when she even asked her daughter "to lend" toys to her. She realized she was "an adult in a situation of competition and rivalry with a little infant." The mother also began to think about what memories Allegra would keep of her infancy, and she asked the therapist, "Is it important to her to feel something with me, to share feelings with me?"

From Allegra's 9th–12th months, intersubjectivity was at the core of the sessions. At that time, the thera-

pist felt that this mother and her baby girl had never met, never shared either pleasure or suffering, even though these last feelings were present both for Allegra, who showed a depression-like attitude in her first months, and for her mother. Actually, Mrs. D. spoke very seldom about her depression, but rather of her exhaustion and her irritation toward the needs and requests of her daughter. The mother felt relieved when her daughter was with her nanny, saying, "I can't bear her more than 2 days running."

Several aspects of this mother–infant psychotherapy would warrant in-depth discussion, which is beyond the scope of this article. At this juncture, we wish to discuss gaze interaction. Serving as a mirror, the mother usually tells the baby what she sees in her baby's face and body, thereby recognizing her affects, needs, and intentions. At the beginning of the psychotherapy, Mrs. D. spoke about her difficulty in looking at Allegra, which might mean recognizing her as her daughter, and being looked at by her as a mother. Speaking about her neglectful behaviors toward Allegra, she explained, "It is more natural for me to be nasty with Allegra than nice: I had to experience this, to know how we feel in the other place, the place of the one who ignores, who beats." We could say the place of the one who looks at a child being ignored, being battered. A few weeks later, she said, "I prefer to see Allegra in the arms of someone else, I can see her, I realize her presence." She then told about a dream where she sees her daughter dying, her head falling behind, and knocking against wood; she then asks for an autopsy. This mother was invaded by very aggressive thoughts and drives that could be conveyed by the look in her eyes. Mrs. D. said that Allegra did not look at her and that she, herself, did not like to look at people or to be looked at. In her personal history, gaze was always the purveyor of indifference, blame, or rejection. Her mother looked at her only with indifference or hate, whereas her father never looked at her. Moreover, Mrs. D. did not understand why Allegra, at 10 months, had started to stand up (she asked, "Why does she stand up? What does she want?"), and she was astonished when the psychotherapist said that Allegra had started to discover the world differently, from another point of view. Mrs. D. could not think and look at the world through her daughter's eyes.

Mrs. D. also showed frightening behaviors with Allegra. In another video sequence at 11 months, Mrs. D. realizes that Allegra is looking at the door and she says, "What are you looking at? Is there anybody behind the door?" Then she says with an odd, squeaky voice: "There is a big bad wolf behind the door!" Then she approaches Allegra, laughs, picks her up in a very abrupt way, and says, "*Mommy* is the big bad wolf!" When she reviewed this video with the therapist, Mrs. D. said she simply wanted to "shake up" her daughter, who always had this sad look in her eyes. She was a mother who saw in her baby the sad child she had been. But the therapist's question might have been "What could Allegra see of herself in her mother's eyes?"

Allegra's Second Year

At the end of the baby's first year, the team still had several doubts about this mother's capacity to carry on having Allegra in her charge. However, Allegra was then showing clear signs of progress in her development, while the mother stated that she was feeling better, that she trusted our work, and that we were helping her to control her mood swings and aggressive drives. After the initial work on intersubjectivity and on helping mother and child to get to know each other and to adjust mutual interactions, we centered our attention on the formation of the attachment/caregiving system.

From the beginning of Allegra's second year, a difficult period started, as the child became more active and autonomous and began to walk and to show some behaviors of defiance and opposition vis-à-vis her mother. While the team was reassured by Allegra's achievement of these developmental milestones, for Mrs. D. the progress in terms of autonomy and individuation of her daughter was synonymous with increasing work and difficulties. She said that Allegra "imposed on her" and "forced herself upon her mother" and that she could not bear that. At the same time, Mrs. D. felt her daughter was leaving her. The rhythms of sleep and feeding were not respected, but were supposed to follow the rhythm of the mother's activities, who was involved in many volunteering activities and self-help and support groups. Considering this alarming situation, the unit team and the child protection services took the issue to a juvenile judge,

who determined a regular supervision of the mother and the child at home by a special education worker and a social worker.

After a team discussion, the psychologist and the pediatric nurse also decided to combine their interventions into one setting, which is called cotherapy. At one end, the therapist (psychologist) serves as a support basis for the parent's exploration of her inner world and current parent–infant relationship, while at the other end the cotherapist (pediatric nurse or infant/young child educator) focuses his or her attention on the infant and reinforces the recognition by the parent of the infant's feelings, needs, and behaviors. While balancing between the needs of both the parent and the infant, this setting prevents the therapist from being submerged with the parent's traumatic past history and present attention needs and helps saving the baby from being "excluded." Both cotherapists, but in particular the pediatric nurse or infant/child educator, act as a spokesperson for the infant. By observing the baby and taking into account his or her contribution throughout the sessions, both cotherapists try to develop parental empathy toward the infant, as well as the parent's identification with the parental role, played to some extent by the cotherapists. This work implies that the two cotherapists have to be fit to work with each other and to regularly adjust treatment focus.

The cotherapy setting proved to be useful in this clinical case. It helped us take into account the infant's increasing needs and contain the mother's aggressive drives toward the child and the therapist. The cotherapists could also function as different maternal identification models. In addition, cotherapy helped to support the acknowledgment of the infant's affective needs and the consolidation of the attachment relationship of Allegra toward her mother.

We feared attachment disorganization, but Allegra was able to organize her attachment behaviors. This may be seen not only as a result of the whole treatment program, but also as evidence of the child's resilience resources. Allegra formed an avoidant attachment pattern in response to her mother's inconsistent availability and responsiveness, and dismissing of her emotional needs. As described by Ainsworth, Blehar, Waters, and Wall (1978), Allegra showed almost no distress when her mother left her for a while (only a brief glance at the mother), she used to ignore or to briefly acknowledge her mother's return, and to avoid proximity by looking or turning away, or reacting negatively to being held by the mother. Interestingly, at that period, and for the first time since Allegra's birth, Mrs. D. showed curiosity about her emotional needs: "Is it true that the blanket is a substitute for the mother? Allegra does not have a blanket, does she not have a mother then? Does she really need me?" We showed Mrs. D. some of Allegra's attachment behaviors that were directed to her, and we encouraged the mother's caregiving behaviors. Mrs. D. was astonished when the therapist said to her that she was the most significant person in the world for Allegra. Mrs. D. realized that she also had affective needs and that she was depressed. She was able to verbalize that "attachment is a shared need."

From Allegra's 15th month onward, positive changes became evident and steady. The mother was no longer depressed and was more attuned to the infant's needs. Mrs. D. said, "It's like my brain is not running as fast." Allegra began to speak and expressed both her positive and negative affects more. Withdrawal behaviors disappeared, even though she remained a little shy. Gradually, they shared more play and emotional experiences. The mother, Allegra, and the cotherapists were very often engaged in dyadic or triadic play or vocal interactions, such as nursery rhymes and puppet games. Allegra seemed delighted while sharing these moments of "being together." At 18 months, Allegra was very often engaged in symbolic play, such as a dolls' tea party, soothing stuffed animals, and showing "maternal behavior" toward the dolls. Throughout Allegra's second year, video feedback was still a valuable tool for the valorization of maternal and infant competencies, for the construction and reinforcement of the attachment relationship, and to help Mrs. D. build a representation of herself as an acceptable mother. Besides, she decided to follow some professional training and found a job. Toward Allegra's third birthday, Mrs. D. also accepted our suggestion to initiate treatment with an adult psychiatrist, in parallel with the mother–child treatment.

Allegra's Third Year

The last year of this mother–child treatment was centered on the consolidation of the attachment

relationship and the stabilization of a positive mother–child relationship. Sessions became progressively less frequent, and treatment was terminated when Allegra was 34 months. Allegra was then a charming but timid little girl, showing some precocity in her development (such as a good level of self-control, politeness, dexterity, and high language skills). At that time, for the first time since Allegra's birth, Mrs. D. showed some concern about the father's role and decided to initiate a procedure to establish paternity and receive income support.

Mrs. D. acknowledged the enhancement of her sensitivity to Allegra's emotional and developmental needs, saying she had "learned to speak the baby's language." She was also more inclined to engage in an in-depth exploration of her own childhood. We could say that there was a "lifting" of the deforming parental projections on the baby and that the mother–child relationship was "decontaminated" of the ghosts of the past, which pushed to repeat with Allegra her past painful experience (Fraiberg et al., 1975).

The lack of memories and of any elaboration of links between affects and representations, or between past and present, as shown by Mrs. D. at the beginning of the treatment, can lead to repetition of past trauma (Fraiberg et al., 1975). When working with BPD mothers, the therapist often has to compensate for the mother's mentalization deficit and help her make links, representing past and present experiences and working on the building of the current relationship with the child. The therapist acts as a reliable parent, providing support and making sense of both the parent's and the infant's experiences. Thinking about their own childhood experience helps parents improve their capacity to understand the internal world of their infant, and to some extent, to resolve past trauma. Thus, the reconstruction or "reconfiguration" (Botella, 2001) of past traumatic experiences that have not been integrated may be one of the treatment's targets. The propensity to repeat old patterns of relatedness and intimacy may be even greater in the perinatal period (Slade, 2002). Therefore, although treatment does not focus on the mother's personality disorder, some elaboration of maternal past history is needed if therapists wish to prevent both the mother from reenacting traumatic experiences and the infant from suffering early relational distortions.

This clinical situation was a very challenging and puzzling work for the whole team. Although we were able to avoid the separation of the child from her mother and although the global outcome could be considered positive, Allegra remained a child at risk, given the fragile and unstable mental functioning of her mother. At the end of the treatment in the parent–infant unit, Allegra entered kindergarten with no apparent difficulties. Mrs. D. was still in treatment with an adult psychiatrist, and the dyad was under the monitoring of the juvenile judge.

IMPLICATIONS FOR RESEARCH, POLICY, AND PRACTICE

The lack of studies of mothers with BPD and their children can be seen both as a challenge and an opportunity. Families of patients with BPD seem particularly at risk of a repetition of relational distortions, mental disorders, and serious family dysfunctions (Beziganian et al., 1993; Lefèbvre et al., 2004). As mentioned above, pregnancy or the birth of a child may lead these patients to seek help, and mental health services need to welcome these parents during this short-lived intervention window. Attendance to treatment is essential considering that the patient is now a parent who is taking charge of an infant. These situations require a therapeutic setting combining flexibility, stability, and availability to achieve the family's compliance.

Assuming a preventive perspective emerges as the most suitable way to help adults with BPD in their transition to parenthood and to prevent the consequences of this mental disorder for the offspring. Mothers with BPD need to be identified early, if possible from pregnancy onward, and provided with an intervention targeted at the experience of the transition to parenthood, focusing on parenting skills, infant communication and needs, and in particular on the parent–child attachment relationship, rather than on the mother's personality disorder. The infant is at the center of the treatment, and only a dyadic approach allows therapists to address the new and specific parental and infant needs. This work seems to be better achieved if shared by several professionals and supported by a larger team. Clearly, more research is needed to understand the transition to parenthood and the parenting difficulties of mothers with BPD, as well as their impact on child outcomes. To date, available

studies on the efficacy of intervening with BPD have focused only on adults. Further studies should therefore evaluate intervention models and outcomes in a parent–child dyadic perspective.

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Received November 10, 2011; revised October 27, 2013; accepted November 28, 2013.