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Personality disorders

Caroline J. Hollins Martin

The act of giving birth has the capacity to precipitate extreme emotional reactions in some women, with parturition shown to be a risk factor for developing psychiatric illness (Brockington, 1996; Paradise, 2002). Statistically 1–20 per cent of all newly delivered mothers experience postnatal mental health problems (Peindl, 2005; Royal College of midwives, 2007; Yonkers *et al.*, 2001). Among this faction are a cohort with pre-existing psychiatric disorders (Knightly, 2008), some of whom have a personality disorder.

Even for people who are mentally healthy, pregnancy evokes novel and challenging thoughts and for some this creates emotional problems (Paradise, 2002). The sorts of worries include concern about the ability to parent, to manage finances, to adjust relationships and to manage any resulting sexual problems. Many factors can mitigate towards or against a positive adaptation to motherhood, but successful transition is hindered when the woman has a poor relationship with her own mother (Murray *et al.*, 1995) or partner (Richards, 1990) or has poor-quality social support (Richards, 1990), low income (Seguin *et al.*, 1999), a history of depressive illness (Beck, 2001), any experience of sexual abuse (Benedict *et al.*, 1999), low socioeconomic status (O'Hara and Swain, 1996; Seguin, 1999), adverse social circumstances (Richards, 1990), an unplanned pregnancy (Warner *et al.*, 1996), unemployment issues for partner or self (Warner *et al.*, 1996) or occupational instability (Murray *et al.*, 1995). These influences, although not directly linked with personality disorders, are critically related to manifestation of their clinical features.

According to the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-IV) personality disorders are characterised by 'pervasive, inflexible and maladaptive' personality traits, which cause significant functional impairment and subjective distress to the individual concerned. There is essential dysfunction in the person's way of thinking, their affectivity and impulse control (Borjesson *et al.*, 2007).

As a consequence, individuals with personality disorder experience accentuated marital problems (Ekselius *et al.*, 1994; Reich *et al.*, 1989) and are more likely to experience psychiatric illness as a product of impaired social functioning (Casey and Tyrer, 1986; Ekselius *et al.*, 1994). Related abnormal thoughts and behaviours create stress through misunderstandings in

communication with caregivers and partners (Borjesson *et al.*, 2007). Enduring manifestations of personality disorder comprise inaccurate attribution of feelings, thoughts and attitudes, especially when the person is stressed (Norton and Dolan, 1996). In general, having a personality disorder augments the customary emotional difficulties and social adaptations that parenthood requires (Borjesson *et al.*, 2007).

What exactly is a personality disorder?

The label incorporates a cluster of mental disturbances that are characterised by enduring thought patterns and behaviour (Borjesson *et al.*, 2007). The American Psychiatric Association's DSM-IV manual (2000) defines personality disorder as an enduring pattern of inner experience and behaviour that differs markedly from the expectations of an individual's culture. The features that present are pervasive and inflexible, with onset in adolescence or early adulthood, and are stable over time, leading to distressed and impaired social relations.

Longstanding maladaptive stereotypical patterns of perceiving and responding to other people in stressful situations are the chief feature. These patterns of inner experience and behaviour are rigid and rooted in a strong drive to self-protect the ego. The difficult behaviour that manifests is different and distinct from the psychotic and neurotic disorders. The DSM-IV (American Psychiatric Association, 2000) reports ten categories of personality disorder (American Psychiatric Association, 2000), which are allocated to three central clusters (see Box 4.1).

Box 4.1 Types of personality disorder (American Psychiatric Association, 2000)

Cluster A (odd or eccentric behaviour)

Paranoid personality disorder
Schizoid personality disorder

Cluster B (dramatic, emotional or erratic behaviour)

Antisocial personality disorder
Borderline personality disorder
Histrionic personality disorder
Narcissistic personality disorder

Cluster C (anxious, fearful behaviour)

Avoidant personality disorder
Dependent personality disorder
Obsessive–compulsive disorder

Cluster A (odd or eccentric behaviour)

Paranoid personality disorder

This is characterised by excessive distrust and suspiciousness of others. A diagnosis is made when these features become enduring, disabling and distressing. Unhealthy relationships due to extreme distrust and hostility often prevail. The combative nature of the individual elicits hostile responses, which serve to reinforce negative expectations of others. There is an extreme need to control others, which is accompanied by rigid, critical and uncollaborative behaviour. The individual with paranoid personality disorder habitually finds it difficult to accept criticism from those they pass judgement on. They often harbour unrealistic and grandiose fantasies and are hierarchical in their comparisons with others.

People who are severely affected are inclined to become fanatics who join cults or groups where their paranoid beliefs can be shared. Psychotic episodes may manifest when the individual experiences stress. The prevalence of the disorder is around 0.5–2.5 per cent of the general population. It is seen in 2–10 per cent of psychiatric outpatients, and is more common in males (American Psychiatric Association, 2000).

Schizoid personality disorder

This personality disorder is characterised by a lack of interest in social relationships. Accordingly, the individual has a propensity towards a solitary lifestyle, secretiveness and emotional coldness (Reber, 1995). Attention is directed towards inner life and away from the external world. Klein (1995) delineates nine manifestations of the disorder: introversion, withdrawnness, narcissism, self-sufficiency, a sense of superiority, loss of affect, loneliness, depersonalisation and regression. There are rich explorations of the schizoid character, most notably from writers such as Seinfeld (1991), Manfield (1992) and Klein (1995). Its prevalence is estimated at less than 1 per cent of the population (American Psychiatric Association, 2000).

Cluster B (dramatic, emotional or erratic behaviour)

Antisocial personality disorder

Individuals with antisocial personality disorder (sociopaths and psychopaths) are unconcerned about the rules of society. As a consequence, they violate the law, display patterns of lying, truancy, delinquency, misuse of alcohol and drugs, run away from home, and have problems holding down employment. Sustaining a marital relationship is often difficult due to expressions of physical aggression, extreme irritability and manipulative behaviour. These problems are accompanied by a lack of motivation to change.

Sociopaths are inclined to be personable, charming and engaging – a demeanour intended to facilitate deception and exploitation of others. Sociopaths and psychopaths lack concern for the feelings of others, are preoccupied with their own interests and convey grandiose expressions of their own importance. Although they are usually above average in intelligence, insight and judgement are ordinarily poor (American Psychiatric Association, 2000).

Borderline personality disorder

The main feature of borderline personality disorder is a pattern of instability in interpersonal relationships, emotions and impulsivity, which persists for years and is closely related to self-image and early social interactions. Frantic efforts to avoid abandonment are often exhibited. The individual prefers intense interpersonal relationships in which they idealise or devalue the other. Further characteristics include an unstable self-image and self-harming activities, such as excessive spending, sex addiction, substance abuse, reckless driving and binge eating. Suicidal behaviour, self-mutilation, moodiness, extreme irritability, anxiousness, intense displays of anger that lead to physical fighting, feelings of chronic emptiness, paranoia and dissociation (such as not remembering periods of one's childhood) are common.

Sudden and dramatic shifts in perception of others are usual, with the person alternately seen as a beneficent supporter or cruelly punitive. Manifestations include shifts from the role of needy supplicant to righteous avenger for past mistreatment. Abrupt changes in opinions and plans about career, sexual identity, values and types of friends are frequent (American Psychiatric Association, 2000).

Histrionic personality disorder

This condition is characterised by excessive emotionality, attention-seeking and failure to achieve passionate intimacy in romantic relationships. The person usually lacks self-awareness. Other manifestations include attempts to control their partner through emotional manipulation, seductiveness and dependency, for instance acting out roles such as victim or princess. Sexually provocative behaviour towards other people's partners often impairs relationships with same-sex friends.

Constant demands for attention occur, with the person craving novelty, stimulation and excitement in frantic efforts to reduce boredom. Jobs or projects are often initiated with an enthusiasm that quickly wears off. Desperate gestures to gain interest and coerce higher levels of care-giving are common. Suicide is uncommon. This disorder presents in 2–3 per cent of the population (American Psychiatric Association, 2000).

Narcissistic personality disorder

Narcissistic personality disorder is characterised by an inflated sense of self-importance, a need for admiration, extreme self-involvement and lack of empathy for others. Individuals with the disorder are often arrogantly self-assured, confident and expect to be considered as superior. A vulnerable self-esteem causes sensitivity to criticism and fear of defeat. Censure may haunt the person with feelings of humiliation, degradation and emptiness. Disdain, rage or defiant counter-attacks are frequent manifestations, with the person's social life being impaired due to problems derived from entitlement, a need for admiration and a disregard for the sensitivities of others. Excessive ambition and confidence often leads to high achievement, but performance is disrupted because of intolerance of criticism and defeat.

Difficulties are often experienced as the person grows old due to a sense of loss of superiority. The prevalence of the disorder is less than 1 per cent of the population (American Psychiatric Association, 2000).

Cluster C (anxious, fearful behaviour)

Avoidant personality disorder

This disorder is characterised by extreme shyness, timidity, loneliness, isolation, feelings of inadequacy, sensitivity to rejection and an inferiority complex. Isolation above interaction is preferred due to prior experiences of pain from loss, rejection and failure to connect with others. As a consequence, the individual develops few close friends and displays dependency on those had. Occupational functioning may suffer through avoidance of social situations that are important for job advancement. The prevalence of this personality disorder is about 0.5–1 per cent of the population and commonly presents in childhood (American Psychiatric Association, 2000).

Dependent personality disorder

Dependent personality disorder is characterised by an over-reliance on others that leads to submissive, clingy behaviour and fear of separation. Social relations are limited to a few people on whom the individual is reliant. Such dependent and submissive behaviour arises out of feelings of being unable to cope without support from familiar others. Complications of the condition include; depression, dependency on alcohol or drugs and physical, emotional or sexual abuse. There is a tendency to avoid positions of responsibility, since anxiety is experienced when faced with decision-making. Chronic physical illness or separation anxiety disorder in childhood may predispose to development of the disorder. It is more frequent in females and is present in about 0.5 per cent of the population (American Psychiatric Association, 2000).

Obsessive-compulsive disorder

This is an anxiety disorder characterised by recurrent persistent unwanted thoughts (obsessions) and repetitive behaviours (compulsions), such as persistent hand washing, repeated counting, checking things and excessive cleaning. The rituals are performed in response to self-doubt and are attempts to dissipate obsessive thoughts. Ritualistic behaviour provides only temporary relief from the anxiety, with omission proliferating affect (American Psychiatric Association, 2000).

General treatment of personality disorders

The American Psychiatric Association (2001) recommends brief hospitalisation in certain instances, namely if the affected person poses an imminent danger to others or makes a serious suicide attempt or presents with psychosis or has severe symptoms that interfere with functioning. In contrast, Linehan (1993) and Paris (2004) believe that hospitalisation can be regressive, harmful and counter-therapeutic. The APA guidelines emphasise that pharmacological treatment should be symptom-specific, so that some patients with multiple symptoms may need to take unlimited combinations of psychotropic medications (Sansone *et al.*, 2003). In one study, Zanarini *et al.* (2004) found that 40 per cent of patients were taking three or more concurrent medications and 20 per cent were taking four or more.

In the emergency room, individuals with **personality disorder and who are** in crisis require rapid, effective pharmacological **treatment** to control the situation and decrease the risk of aggression to themselves or to others. Psychiatric emergency services aim to treat acute clinical problems by administering anxiolytic or antipsychotic medication, modifying existing drug regimens and initiating long-term pharmacotherapy (**Pascual et al., 2007**). Patients with marked mood swings sometimes benefit from two drugs ordinarily used to treat epilepsy, that is Depakote (valproate semisodium) and Tegretol (carbamazepine). Patients with severe depression may benefit from antidepressant medication. Small doses of the neuroleptic drugs typically used for schizophrenia sometimes help borderline patients in periods of severe stress. Lithium is sometimes helpful and may make it possible to use lower the doses of other drugs. Minor tranquilisers (such as Valium (diazepam)) or sedatives (such as Dalmane (flurazepam)) should be considered only with caution since they are dangerously habit forming. Since the majority of drugs cross the placental barrier during pregnancy and permeate breast milk, caution is required by the prescribing officer.

By the time the person has been diagnosed with personality disorder, so much stress will have been generated in the family that everyone is affected. Outpatient treatments consists of analysis sessions spread over a period of years (Moran and Hayward, 2007) in which the therapist works with the patient to understand motives and meanings behind their behaviour and focuses on strengthening the patient's capacity to endure frustration, anger and loneliness without acting impulsively on those feelings. Cognitive-behavioural therapy is one therapeutic approach (Davidson, 2008). In general, the aim of this therapy is to focus on the feelings that underlie the associated problems of 'thinking in black and white'. Furthermore, the patient's family may be trained to set limits with the patient, rather than giving in to their threats and unreasonable demands.

Personality disorder and mental health in the perinatal period

There is a dearth of research directly relating to personality disorder and the subsequent development of mental health problems in the perinatal period. To date, little has been written about functional impairment that personality disorder causes. Also, no associations have been made between the subcategories of personality disorder (see **Box 4.1**) and establishment of postnatal mental health symptoms.

There are of course generic traditions of modeling, explaining, advising and managing women at risk from developing postnatal mental health problems, with several standardised practices that are designed to enable practitioners to detect, recognise and manage the related psychological disruption. Healthcare professionals have a responsibility to recognise, support and treat child-bearing women with a personality disorder.

Counselling women with personality disorder about having children

Questioning whether a woman with personality disorder should have children can be a source of anguish for healthcare professionals, the woman and her family. Pursuing conception is a decision that should be made exclusively by both parents and need not necessarily be an automatic response to getting married or settling down.

Before deciding to have children, several factors should be considered:

- How much impairment does the personality disorder cause to the woman's interpersonal functioning in daily life?
- Are there frequent misunderstandings with friends, family and partners?
- Are misunderstandings enduring, stressful and persistent?
- Does the woman have frequent interaction problems or only a few episodes?
- How manageable are the problems that manifest from the mood disorder?
- How much support can the woman expect from her partner after the birth?
- How does the woman cope with everyday life right now?
- Can the women hold down a job?
- What is the couple's financial situation?

In general, personality disorder holds people back, with many taking longer to complete schooling or to achieve in job training (Seivewright *et al.*, 2004) and many struggle to commence independent adult life (Skodol *et al.*, 2007). Consequently, couples should be counselled to perceive how they imagine they would cope with the additional responsibilities of managing a baby. One approach involves encouraging the couple to talk to parents with small children, so they experience the joys and strains of parenthood by proxy, which may improve their insight into the responsibilities involved. It is important for the couple to realise that having a baby will not solve any life problems or stabilise a jaded or difficult relationship (Qu *et al.*, 2000). Instead, child-bearing and rearing add more burdens to what could be considered an already stressful life.

Understanding the effects of child-bearing on mood

Many healthy women experience mood swings after giving birth. Transient mild depression and crying spells occur in 60 per cent of women between the third and tenth postnatal day (Stein, 1984). This condition is labelled the 'baby blues' and incorporates feelings that range from detachment (wondering whether the baby really belongs to them), joy and satisfaction, to weepiness and feeling let down. Mood swings are propagated by the enormous physical and emotional stress involved in giving birth (Dalton, 1996). Healthcare professionals require to appreciate that mothers who experience the 'baby blues' are more likely to develop postnatal depression (Gibbon, 2004).

Symptoms of postnatal depression can occur anytime within the first year (Beck, 2001). Clinical features include sadness, hopelessness, low self-esteem, guilt, sleep or eating disturbances, an incapacity to be comforted, exhaustion, emptiness, an inability to gain pleasure from activities previously enjoyed, social withdrawal, low energy, and feelings of frustration and inadequacy in taking care of the baby. Impaired communication and anger towards others increases the likelihood of experiencing anxiety or panic attacks (Beck, 2001).

Maternal depression can also effect the infant's emotional and cognitive development (Rothman, 2006). Possible effects include formation of an insecure infant-mother attachment (Department of Health, 2002; Meredith and Noller, 2003) and difficult behaviour (Barlow and

Parsons, 2003; O'Connor *et al.*, 2002). Cognitive effects relate to poorer than normal mental and motor development (Cox and Holden, 2003; Sinclair and Murray, 1998). Poor maternal mental health is associated with limited responsiveness to the child's needs and is associated with deficient parenting (Kotch *et al.*, 1999). The stress of poverty augments existing difficulties (Casanueva *et al.*, 2007).

A third classification of postnatal mental disorder is 'puerperal psychosis'. This condition manifests with auditory, optical, nihilistic or persecutory delusions, confusion, misrecognition, mania, stupor and mutism (Klomprouwer *et al.*, 1995). Postnatal depression is clearly differentiated from psychotic depression (World Health Organization, 1992).

The stress of child-bearing and child-rearing causes 10–20 per cent of women with no personal or family history to develop mental health problems in the perinatal period (Knightley, 2008). A woman with the disorder is even more 'at risk' of being counted in this group. Several interventions are aimed at reducing their levels of physical and emotional stress. Since psychiatric illness and suicide are the leading cause of maternal death in the UK (Confidential Enquires into Maternal Death, 2002; Sullivan *et al.*, 2003), it is imperative that services adequately support women in the 'at risk' category of developing postnatal mental health problems (Confidential Enquiries into Maternal Death, 2002; Confidential Enquiries into Maternal and Child Health, 2004; Ross-Davie *et al.*, 2007).

Interventions designed to help postnatal women make the necessary adjustments are listed in Box 4.2.

Box 4.2 Interventions designed to help women to adjust in the postnatal period

- Providing specialist mental healthcare for all child-bearing women with diagnosed mental health problems.
- Writing protocols that direct management of women who are 'at risk' of developing postnatal mental illness.
- Commissioning routine systematic and sensitive enquiry about the psychiatric history of all child-bearing women at the antenatal clinic.
- Producing accurate records of the child-bearing woman's psychiatric history.
- Providing specialist psychiatric review for women with a history of severe mental illness.
- Writing management plans for those 'at risk' of developing postnatal mental health problems and place these in the hand-held notes.
- Providing a home help or lengthening the hospital stay.

CEMACH (Confidential Enquiries into Maternal and Child Health, 2004) states that training in perinatal psychiatry should be included in the curricula and continued professional development of all midwives, health visitors and doctors.

Changing attitudes towards women with mental health problems

Attitudes towards people with mental health problems have changed to some extent, with more positive responses resulting from media exposure and education (Wallach, 2004). However, branding with a woman with the label personality disorder may cause some to see her as an ‘unfit parent’, when in fact her performance cannot be measured until after the event.

Recognising women risk of mental disequilibrium in the perinatal period

Women, as well as healthcare professionals, should recognise anyone ‘at risk’ of developing mental health problems. Several variables promote or hamper the transition to parenthood. Personality disorder, by virtue of diagnosis, creates problems with interpersonal functioning (Borjesson *et al.*, 2007) and this augments the routine stressors in the postnatal environment. Brown and Harris (1978) identified four predictive features that may contribute to mental health disturbance in the perinatal period (Box 4.3). When all four of them are present, 100 per cent of mothers become depressed.

Box 4.3 Four factors that may contribute to mental health disturbance in the perinatal period (Brown and Harris, 1978)

- Lack of an intimate relationship.
- Three or more children under the age of 14.
- Loss of own mother before the age of 11.
- No employment outside the home.

These Brown and Harris predictors are used by healthcare professionals to forecast who is in the ‘at risk’ category for developing a mental health disturbance in the perinatal period. Further predictors of mental health disturbance include factors such as the woman having a poor relationship with her own mother (Murray *et al.*, 1995) or partner (Richards, 1990) and reduced social contact and support (Richards, 1990). Problems are compounded by the thinking distortions associated with personality disorder (Beck, 2001), which increase vulnerability towards cultivating postnatal mental health problems (Stamp *et al.*, 1995).

Child-bearing women with a history of sexual abuse (Benedict *et al.*, 1999), of low socioeconomic status (O'Hara and Swain, 1996; Seguin *et al.*, 1999), with adverse social circumstances (Richards, 1990), an unplanned pregnancy (Warner *et al.*, 1996), unemployment of partner or self (Warner *et al.*, 1996) and those with occupational instability (Murray *et al.*, 1995) are also at risk. A myriad of precursors may compound the postnatal woman's ability to cope (see Box 4.2).

Table 4.1 Factors promoting positive/negative adaptation to motherhood

Positive adaptation	Negative adaptation
Good feelings for baby	Poor feelings for baby
Appropriate sleep pattern in baby	Poor sleep pattern in baby
Content baby	Irritable baby
Joint conjugal roles	Separated conjugal roles
Support from family and friends	Social isolation
Enjoys motherhood	Dislikes motherhood
High self-esteem	Low self-esteem
:Likes new social identity	Loss of work identity
Responsive baby	Unresponsive baby
Satisfying birth experience	Difficult birth

Healthcare professionals require to measure adaptation to motherhood, particularly in a woman with personality disorder, since she has additional problems with interpersonal functioning, affectivity disorder and impulse control (Borjesson *et al.*, 2007). The Edinburgh Postnatal Depression Scale (EPDS) (Cox, 1986; Cox and Holden, 1994) (see Box 4.4) is a tool designed to detect depression in postnatal women. It asks simple questions about the mother's emotions and feelings over the previous seven days.

Inter-role and intra-role conflict

Inter-role conflict arises when two or more roles demand different behaviour from the same person (Roth, 1995). For example, a midwifery sister has to interact and deal with conflicting demands from both workers and management within the same organisation. Likewise, a woman's partner may exact her attention in chorus with her newborn. Conflicting demands such as these cause stress. Another form of disharmony occurs when there are two sets of expectations from the same role (Roth, 1995). This is termed intra-role conflict. For example, some people hold expectations that a woman should stay at home with her newborn, while others pre-suppose that she continues employment and engages a childminder. The woman must select and deal with the stress and conflict that may ensue. The media presents relentless representations of the ideal mother as a well-dressed, smiling, beautiful, sexy individual with clean, happy children. The mother may actually be dishevelled, miserable, fatigued, sexually disinterested and have unkempt and challenging children. Such mismatched constructs of the ideal versus reality will inescapably inflate a woman's internal conflict and generate dissatisfaction. A lowered self-esteem may result, with adjustment dependant on coping strategies implemented (see Fig. 4.1 overpage).

Box 4.4 Edinburgh Postnatal Depression Scale (EPDS) (Cox ,1986)

Instructions to mother: As you have had a baby, we would like to know how you are feeling now. Please indicate the answer which comes closest to how you have felt in the past week. In the past 7 days (please tick as appropriate):

1. I have been able to laugh and see the funny side of things

As much as I always could
Not quite so much now
Definitely not so much now
Not at all

2. People upset me so that I felt like slamming doors and banging about

Yes, often
Yes, sometimes
Only occasionally
Not at all

3. I have looked forward with enjoyment to things

As much as I ever did
Rather less than I used to
Definitely less than I used to
Hardly at all

4. I have blamed myself unnecessarily when things went wrong

Yes, most of the time
Yes, some of the time
Not very often
No, never

5. I have been anxious or worried for no good reason

No, not at all
Hardly ever
Yes, sometimes
Yes, very often

6. I have enjoyed being a mother

Yes, very much so
Yes, on the whole
Rather less than usual
No, not very much

7. I have felt scared or panicky for no very good reason

Yes, quite a lot
Yes, sometimes
No, not much
No, not at all

(continued overpage)

Box 4.4 Edinburgh Postnatal Depression Scale (cont...)

9. I have been so unhappy that I have had difficulty sleeping

- Yes, most of the time
- Yes, sometimes
- Not very often
- No, not at all

10. I have felt sad or miserable

- Yes, most of the time
- Yes, quite often
- Not very often
- No, not at all

11. I have felt I might lose control and hit someone

- Yes, frequently
- Yes, sometimes
- Only occasionally
- Never

12. I have been so unhappy that I have been crying

- Yes, most of the time
- Yes, quite often
- Only occasionally
- No, never

13. The thought of harming myself has occurred to me

- Yes, quite often
- Sometimes
- Hardly ever
- Never

A total score of more than 16 indicates the patient is depressed.

Conclusions

Healthcare professionals working with child-bearing women are required to identify those at risk of developing mental health problems. A woman with a personality disorder is clearly in the 'at risk' group and therefore should be appropriately prepared, monitored and supported during pregnancy and the perinatal period (Henshaw, 2005). There is considerable scope for healthcare professionals to make a difference (Department of Health, 1999). In order to be effective, midwives, health visitors and doctors have training requirements, as requested in the Why Mothers Die report (Confidential Enquiries into Maternal and Child Health, 2004).

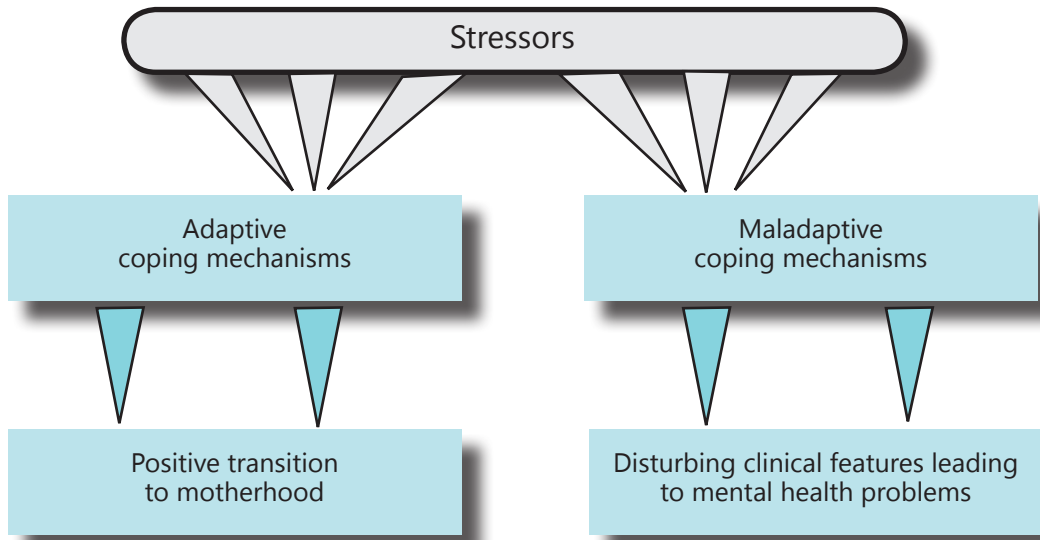


Figure 4.1 Adaptation to stress.

Several factors may work towards improving mental health management in the antenatal and perinatal period (Moss-Davie *et al.*, 2007). These include:

- Service development and practice improvement in provision of care for pregnant women and new mothers with mental health problems.
- Establishing an accurate mental health history at the booking visit (by the midwife).
- Teaching healthcare professionals to provide high-quality care aimed at improving perinatal mental health records.

At an academic level, more research into perinatal mental health and its relationship to personality disorder is recommended. There are many unanswered research questions. For example, in what way does child-bearing and child-rearing cause the family life of a woman with a personality disorder to become disturbingly stressful? What helps a partner or family cope when a woman with personality disorder is diagnosed with perinatal mental health problems? How does child-bearing and child-rearing exacerbate the clinical features of personality disorder? How does personality disorder affect adaptation to motherhood? Does personality disorder hasten or exacerbate postnatal depression? Can women with a personality disorder pass the condition onto their children? What factors help women with personality disorder cope with child-bearing and rearing?

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