THE BPD ADVOCATE

Issue 3

SUMMER 2018

BPD Conference Review

Australia's Borderline Personality Disorder Conference was held in Perth, WA for the first time, and was deemed a great success!

The National BPD Conference was attended by politicians, the WA Mental Health Commission, the WA Dept of Health as well as people with lived experience of BPD, families, carers and mental health professionals. Dr Peggy Brown, National Mental Health Commissioner declared it is time BPD was made a priority for mental health service development. This was also affirmed by Professor Ian Hickie, Mental Health Commissioner and Director of the Brain Mind Institute who acted as ambassador for BPD Awareness Week 2017. See reviews of the Conference inside.

BPD Awareness Week was promoted across Australia during October with the help of an expanded group of organisations and individuals. Events held included a Forum, Art Exhibition, Family Fun Day, Celebration and Movie Night. In addition, we saw the launches the WA Branch of the Foundation, a BPD Mental Health Professional Network in Sydney, and the National BPD Training Strategy in Melbourne.

The Annual General Meeting of the Australian BPD Foundation was held on November 27th. Retiring board member Rita Brown was re-elected to the Board. Karen Bailey and Dr Peter McKenzie also retired as co-opted board members and were elected to the Board. Appreciation was expressed for the enormous voluntary contributions of all board members that are so important in continuing the work of the Foundation. The Annual Report and Annual Financial Report are available on our website. Guest Speaker Dr Haley Peckham gave an inspiring presentation, 'The Talking Cure is Biological' using her experience of, and recovery from, complex trauma. Her presentation was informed by a synthesis of her studies of molecular neuroscience, neuroplasticity, psychotherapy, mental health nursing and philosophy.

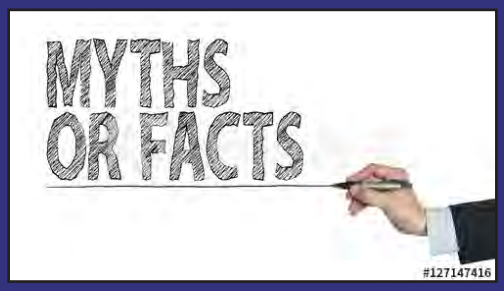
The BPD Advocate team wish you a peaceful festive time and may 2018 be a year which is good for you and those you love.

Julien McDonald

President, Australian BPD Foundation Ltd

Australian BPD Foundation Limited
Support Promote Advocate for Borderline Personality Disorder

Is BPD Caused by Trauma?



"BPD is Caused by Trauma"

On average about 50% - 60% of people with BPD will have a history of trauma. Of course that also means that about half the people with BPD don't have a history of trauma, so it's not at all accurate to say that BPD is caused by trauma.

In any case, even for people who do present with a history of trauma, it's not as simple as saying that their trauma caused their BPD – and you must remember that the commonest outcome for people who do experience childhood trauma is to grow as a healthy adult, and not to develop a mental disorder.

The kinds of things that may start a disorder are not necessarily the same things that intensify or perpetuate it. The causes of BPD are multifactorial and there are all sorts of cascading events that occur that play a major role after the original trauma has long gone.

People get deeply offended when you say it's a myth that trauma causes BPD but I also think it's equally offensive to people who haven't had histories of trauma to say either that they must have been traumatised and they don't know it, or to disrespect their experience of developing BPD through another pathway.

Families suffer when there is an assumption that they are to blame. I think BPD is the last disorder that has this legacy of family blaming. I have been around long enough to remember when families were blamed for schizophrenia and autism – through, respectively, the theory of the schizophrenogenic mother and the refrigerator parent. There's a whole legacy of blaming families in psychiatry that I am not very proud of.

Parents are not to blame but they are not off the hook either; they are clearly involved. And so we need some kind of solution that allows families to be involved but not discriminated against and blamed and marginalized from the whole thing. I think families and carers should be a big part of the patient's recovery - but try telling some psychiatrists that.

This 'Myth or Fact' was supplied by Professor Andrew Chanen, Head, Personality Disorder Research at Orygen.

Lived Experience

Alice, 22, found structured therapy from a single therapist helpful

I got unwell when I was about 14 and living in Western Australia. At that age I was mostly experiencing problems with relationships and relating to people. My way of asking for help was to engage in risky behaviour and to self-harm. At the same time I had an eating disorder, which took centre-stage.

Around this time my mother moved to NSW, leaving me with my father. Mum leaving felt like an abandonment even though she'd asked me to go with her – but that felt too scary. I didn't like change or the idea of having to leave my school and friends.

When my father found out I was very unwell he pretty much said I don't want you to live here anymore. That reinforced my feelings of not being worthy. So I stayed with a friend for a while before I went to live with my mum in NSW and then Victoria. She didn't know how unwell I was until my school notified her that I was self-harming. I'd hid it from her for a long time because I felt guilty about it.

Despite being treated by CAMHS [Child and Adolescent Mental Health Service] I found myself admitted to medical and psych wards frequently. I was hospitalised for the eating disorder and the self-harm got out of hand. I was in emergency a lot. By this stage I had heard about BPD and I went to my CAMHS worker and said I think I have BPD because I was experiencing such extreme emotions. I would react to something and could be suicidal within seconds. Something was not right.

My CAMHS worker came back and said that is not a diagnosis we're willing to give you – even though I later saw in my medical records that they had diagnosed me with BPD but didn't tell me. I assume that was because they were stuck in the mindset that a diagnosis should not be made on someone under 18.

So we got private health insurance and I went to see a private psychiatrist and he soon diagnosed me with BPD. This was a real relief, a validation. With every trip to emergency I thought what a shitty daughter I am, what a horrible person. At the same time I thought I deserved it all. It wasn't until someone said this is what's wrong with you, this is why you can't handle your emotions, this is why you're doing this, that that started to shift. For the first time I recognised that there was something wrong with me and that it could be treated.

While all this was happening I was struggling at school, but I did a lot of schoolwork in hospitals and still managed to pass. One day when I was in hospital, physically unwell with my eating disorder, I was told by CAMHS that they were discharging me because I was too difficult. After that I went to a private clinic for a few months.

My private psychiatrist put me on to a therapist who did CAT [cognitive analytic therapy] which definitely saved my life. I had very structured sessions with my therapist. CAMHS thought my eating problems were driving everything but once I started having therapy for BDP my eating improved and I came off a lot of my medications. I started making little steps forward, like getting my driver's licence when previously I'd been too anxious. Until then, even though I was 18, I wouldn't go anywhere without my mum and step dad.

Having the consistency of a single therapist helped. Doing CAT meant I had to put work in and that I was accountable for the treatment. Another part that helped me was drawing maps; like a map of a particular trigger and what my brain goes through after that. Things like guilt, which makes you want to punish yourself, which creates more guilt. The maps helped me see to visualize things and see common cycles of behaviour.

After my therapy ended I moved back to WA and reconnected with old friends. I also went travelling by myself, which was great. I'm working now too, part time, while studying full-time.

I still experience triggers and have problems calming myself down if I get upset. The biggest thing now is that I know how to sit with the distress. In the past, I'd need to self-harm, whereas now I can sit with it, have a cry, or talk to someone. I don't really know if it will go away but I know how to deal with it. That makes such a big difference.

Carer's Corner

It was many difficult years before Queensland couple Liz and David realised their daughter, Isabella, 24, was not simply misbehaving

Liz: From age 12, Isabella became an angry child and very hard to relate to. She also seemed to become very self-centred.

David: This was a big change from the happy, outgoing, and funny child she'd been before. This made for a very unhappy family life. Before the BPD diagnosis comes along you think – and others do too – that she is simply rude and badly behaved. That can remain until you realise the angst and suffering behind the scenes.

Liz: It wasn't until her 20s that we discovered she'd been badly bullied at school. She didn't tell us about it. This made her hyper-sensitive to minor criticisms or the natural ups and downs of friendship.

David: Her friends didn't understand her behaviour, and it started to destroy her relationships and isolate her.

Liz: In Year 11 she was diagnosed with acute social anxiety. We couldn't believe it as she's so extraverted. But it seemed she has an acute awareness of how she's seen by others.

In Year 12 Isabella had meltdowns but she managed a good ATAR before deciding to take a gap year. Her priority was to make friends – that represented being normal to her. She had a relationship, too, but he ended up doing an exchange overseas and she felt totally abandoned.

David: Within days of him going we found out that Isabella was texting him saying she was going to kill herself and it was his fault. We were stunned.

She then had what I'd call a breakdown; weeping on the floor for up to eight hours a day, for months. We often had to call a crisis team. We were on suicide watch.

Liz: At this time, when she was 22, she was diagnosed with borderline personality disorder traits.

David: That was a huge relief because it meant we weren't just dealing with a 'bad person'. She was mentally unwell. We were lucky to have each other during these times, and friends, artistic pursuits and exercise helped us cope, but seeking support – like Family Connections – really turned things around for us. Previously I'd react with anger to Isabella's behavior. I learnt that it's so much easier if you're validating. We seem to have a much better relationship with her now.

Liz: We handle her outbursts so much better which helps Isabella and the household.

David: The BPD diagnosis started our connection with mental health professionals. We often saw a lack of professionalism and training. Some professionals would tell us Isabella needed tough love, which is the absolute worst advice as it just exacerbates things. Another said we should try to calm her down with fragrant candles!

David: We have seen lots of positive changes and we all feel more hopeful. Besides working and studying, she started a DBT [dialectical behavior therapy] course and although she didn't complete it she said it has helped her cope better. Medication seems to also have had a stabilising effect, because she hasn't had serious troughs of despair.

I think she better understands her herself. We really hope she'll complete the DBT. We know she wants to live a happier life. She will have to accept herself and not hate herself and accept the past. She seems a lot happier. We're optimistic.

** Names have been changed*

Ed. "Research shows that 'good clinical care' in addition to a variety of therapy programs like DBT, ACT, Mentalization (MBT), CBT are equally valuable in treatment of BPD. Importantly, if one form of treatment is not suiting you, try another. For more information refer to the NHMRC Clinical Guidelines: https://www.nhmrc.gov.au/guidelines-publications/mh25"

National BPD Conference Review

Keynote Address: Clinician Building a healthcare system response to BPD

The explosion of knowledge about BPD has provided solid ground for early diagnosis and treatment of both sub-threshold borderline personality pathology and full-syndrome BPD, says Orygen's Professor Andrew Chanen. Yet BPD diagnosis is usually delayed and specific treatment is only offered late in the course of the disorder.

Moreover, he says, the BPD treatment literature misleadingly implies that lengthy individual psychotherapy is both necessary and sufficient for the treatment of all individuals with BPD, despite evidence that such services are inaccessible to most people with BPD, that 'high-quality care' might be as effective as 'branded' psychotherapies, and that intermittent care might be effective.

According to Professor Chanen service delivery models are required that recognise the heterogeneity of BPD, and that support a range of treatment options, at all levels of the health system, which are appropriate and proportionate to the phase and stage of disorder. "Clinical staging," similar to disease staging in general medicine, is presented as a pragmatic, heuristic, and trans-diagnostic framework to guide prevention and intervention for BPD across the life course.

A summary of some of Professor Chanen's main points follows:

* We need to build a better health system response to BPD because it is the most common disorder in the psychiatric system. One to five per cent of the population have BPD at some time in their lives, and 50% of all psychiatric patients have some form of BPD.

* The service system is not fit for purpose for BPD: There is no coordination of the service system; fee for service is unsuited to most people with BPD; access to evidence-based treatment is poor and dropout rates are high.

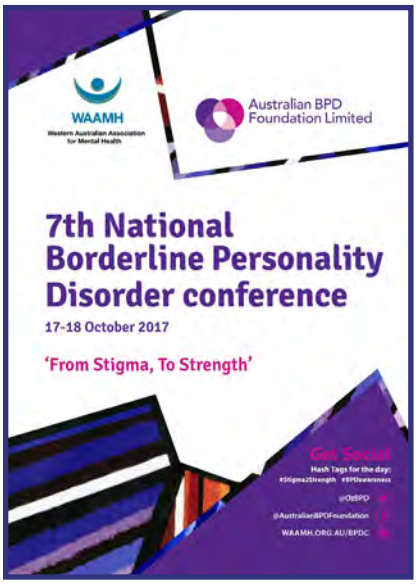
* Clinically-speaking, individual psychotherapies are only moderately effective and therefore more needs to be done. Clinicians focus too much on self-harm versus meeting patient needs.

* Early intervention (which means early in the course of the disorder – not related to age) is vital. BPD at age 14 predicts poor academic involvement and also less ability to have an occupation. Furthermore, 57% of 15-24 year old people are not in education, employment or training. Also 40% of 20-24 year-old people with BPD do not finished year 12.

* Yet for all that we do not treat BPD early but wait till "eggs are scrambled" and then try to help. Diagnosis is often delayed, and only treated when there is functional impairment and complications are entrenched. Delaying diagnosis – even if that's due to a fear of imposing stigma – is harmful and discriminatory. Clinicians who observe colleagues being disparaging around BPD should take them on. The best thing a clinician can do is advocate for their patients.

* Most self-harm emerges early – post puberty and before adulthood – so we must intervene early. The health system does not argue for late intervention in any other area of health. This does not happen with, say, breast cancer, cardiac issues. The system turns away people diagnosed with BPD till they become much worse. It virtually says, "try to kill yourself harder, and then we'll treat you."

* Stigma comes from the mental health community, not the general community. Clinicians don't say they won't treat people with gastro problems because they are smelly,



Your local MP may be interested to learn about how to improve BPD services. You can draft your own letter or use the template on the 'Spread the Word' link on the BPD Awareness Website

https://www.bpdawareness.com.au/spread-the-word/

Letters to the Editor

P&O LEARN ABOUT BPD

Dear Editor,

In August my daughter and her partner went on a P&O cruise through the Pacific. As this was her first time travelling without one of her parents she was understandably very excited. Yet on day three her cruise was ruined when, to her distress, she was the victim of the kind of discrimination all too commonly faced by people who've experienced mental ill-heath.

She and her partner were in an onboard food court when a security guard confronted her and requested she accompany them to a private room for questioning. Security, and an attending member of medical staff, told her that someone had reported her "appearing distressed". "Cuts", they said, had been noticed on her arms.

Over the course of an hour my daughter advised them that at no time had she been distressed and that while she had old scars on her arms they were not cuts. They requested to take photos of her arms and a medical officer proceeded to question her regarding her mental health history – which includes her struggles with BPD and, some time ago, self-harm. They also questioned her partner about my daughter's medical history and the stability and personal nature of their relationship. After this was done the staff at this time advised my daughter and her partner that they had the power to remove them from the ship (at no time did they give any reason for why this may occur). In the end my daughter and her partner were advised that they could remain on the ship but that they would be watched and my daughter's alcohol consumption would be monitored.

I understand that P&O have an obligation to ensure safety and security for all passengers and staff on board their cruises. However, as was made clear very early on in discussion with my daughter, any concerns they may have had were totally unwarranted and extremely discriminatory.

I am pleased to advise that, after a strong letter of complaint, P&O have acknowledged their fault and apologised in writing with a full refund of cruise fare to both my daughter and her partner. They also acknowledged that the extent of the personal questioning, and the alcohol monitoring, was over the top and inappropriate.

In my letter I also implored them to review their policy and procedure in regards to mental health. Having a company policy to ensure the safety of guests and crew is all well and good but does that mean that anyone with scars on their body, or any other unusual appearance, has the potential to be interrogated in a similar fashion?

Thanks to the hard work of both Jeff Kennett and now Julia Gillard (Chair of Beyond Blue) and Stigma Watch of media by Sane Australia, mental health issues are been far more readily acknowledged and treated in a more positive and supportive nature. Their mission statements are is focused on reducing stigma and discrimination helping all Australians affected by mental illness lead a better life.

I would like to see P&O and other organisations seek advice from groups like Beyond Blue and Sane Australia in formulating more progressive policies and procedures.

Jennie Jones

Review (cont...)

but they do say they won't treat people with BPD because they have interpersonal issues.

* Prevention cannot happen in isolation and needs to be integrated with other mental illnesses. BPD overlaps with mood disorders, eating disorders, anxiety, etc. Risk factors for BPD are risk factors for all mental illnesses. At the early stage we need to look at the broad risk syndrome. We don't know if the symptoms will become, schizophrenia, BPD or an eating disorder.

* Medication should only be given for co-occurring problems and then only at the right level. For example if symptoms are really bad clozapine may be prescribed, but meds must always be reassessed.

* Evidence-based treatments should be characterised by structured (manual directed) treatment of BPD problems where the consumer is encouraged to assume agency. A therapist helps connect feelings to actions and is activate, responsive and validating. Silence is filled with threat.

Professor Andrew Chanen is Head, Personality Disorder Research at Orygen.

National BPD Conference Snapshots

Snapshots from Conference Prensentations

LIFTING THE LID - IT'S TIME FOR A NATIONAL FOCUS ON BPD': DR PEGGY BROWN

"We know access to effective treatment is really haphazard across the country. I can't think of another mental health issue that has the same comparable stats and the same lack of systematic access to effective treatment. That's why the National Health Commission thinks we need a national focus on BPD. And it's why we've been pleased to sponsor the training, this conference today and to commission a spotlight report [on borderline personality disorder]."

Dr Peggy Brown, Chief Executive Officer, National Mental Health Commission. Dr Brown commenced as Chief Executive Officer of the National Mental Health Commission in October 2016.

'FROM STIGMA TO STRENGTH - A CARER PERSPECTIVE': RITA

"We know all too frequently that people with lived experience of BPD are exposed to stigma and discrimination. The same is also true for carers who themselves often also experience intense emotional distress. I encourage services and clinicians to regard families as an integral and vital part of the treating team. The consistent support of others plays a vital role in supporting the person experiencing the distress of BPD. To take on this role carers themselves need support and psycho-education to learn new skills, both to help them relate in a more supportive way to the person with BPD and to manage their own well-being in often difficult circumstances.

Those involved in administration are encouraged to acknowledge the importance of involving the lived experience of both consumers and carers in research, strategic planning, policy development and implementation to ensure that whatever program their organization offers is of the most relevance and support to the people it claims to assist.

Rita is a board member of the Australian BPD Foundation.

'FIGHTING STIGMA AND FINDING STRENGTH': SONIA NEALE

"I turned stigma into strength by using my diagnosis and making it work for me, rather than against me. I decided to fully own my BPD. That was the best decision I ever made. I set out to learn everything I could and started studying at university for my psychology and counselling degree. Knowledge is power. Self-empowerment in the face of adversity is vital to understand who we are and what we do and how we feel. University gave me confidence and knowledge. Self-development gave me a sense of identity. I know that I could still have intense feelings but what I chose to do with them and how to remain in control was my choice, my decision.

"A good therapist works with a client, not against them. The wrong treatment is stigmatising. She does not provide me with the answers. She provides me the right question for me to find the own answers for my life – because I know my life best. Therapy is not for the faint hearted. It requires a bucket load of strength. The right question is one that pierces the heart. The right answer staunches the blood flow to take the painkillers and bandages away."

Sonia Neale is a NGO Mental Health Peer Support Worker helping people with mental illness find their strengths and skills to achieve their goals. Sonia was the recipient of the Inaugural SANE Australia Barbara Hocking Fellowship in 2014.

BUILDING BRIDGES & FENCES - CORE TREATMENT STRATEGIES FOR BPD: A/PROF S. RAO & MS TERESA STEVENSON

"Central challenges involved in psychotherapy for BPD are dealing with counter transference and dealing with pressures to transgress boundaries. The term 'countertransference' has been given various definitions but for my purpose here, one broad definition of countertransference [from James F Masterson] is 'all the emotions in the therapist that interfere with the ability to provide a therapeutically neutral frame' for the client … There are two people in the room and one can be more troublesome than the other – and it's not necessarily the client. Sometimes it can be you [the mental health clinician]. Sometimes it can be your stuff and it can be triggered and you need to be aware.

Ms Teresa Stevenson (Clinical Psychology Coordinator & Senior Clinical Psychologist, Peel & Rockingham Kwinana Mental Health Services).

Presentations from our 2017 Annual Conference 'From Stigma to Strength' are available online at:

https://bpdfoundation.org.au/news.php?newsid=15

International PD Conference

PROJECT AIR - TREATMENT OF PERSONALITY DISORDERS CONFERENCE 2017

Consumer and Carer Day

On the 2nd November the Project Air Consumer and Carer Day was held in conjunction with their 11th Annual Personality Disorders Conference at the University of Wollongong, NSW.

It was a day filled with lived experience presentations ranging from '*Reimagining Mindfulness Techniques & Practice*', *'To the Moon and Back' (*about recovery from trauma), a mother-daughter perspective of personality disorder, and a discussion on opportunities and challenges for peer support workers in Australia.

The day also included a consumer and carers roundtable where participants discussed consumer and carer perspectives on priorities for the future of care for personality disorders.

Wrapping up the day was '*Peer Support for People with Borderline Personality Disorder: A Peer and Clinician Co-Facilitated Group Intervention*' which included the launch of the **Project Air Peers** program. This was developed for people with BPD seeking support from others with similar experiences. The presentation explained the model and how to run a peer-led group for BPD. This program is now seeking expressions of interest from organisations able to trial the program. For more info email projectair@uow.edu.au

Project summary will be released soon at www.projectairstrategy.org

Rita

Project Air - 11th International Conference on the Treatment of Personality Disorders 'Understanding Narcisstic Personalities and other Relationships'

Clinicians and Workers - online presentations

Consumer & Carer Day - details

BPD Centre for SA

NEW BPD CENTRE OF EXCELLENCE TO BE ESTABLISHED IN 2018

SA Dignity Party's MLC Kelly Vincent has negotiated $10.25m funding to build and staff a BPD centre in SA for complex presentations.

The 'hub and spoke' model provides for specialised consultation, strong links with community mental health services, step-up/step-down care, education, training and consumer/family carer support. The SA Centre of Excellence Model has been developed from the SA BPD Action Plan prepared by the SA Mental Health Commission.

Work is expected to start on the BPD Centre of Excellence early in 2018.

The Hon Kelly Vincent also raised the Robert Burke Motion in SA Parliament Upper House on Nov 29th to honour and remember the late Bob Burke, a winner of the Dr Margaret Tobin Award for his work, together with his wife Judy, in establishing and running the Sanctuary support group for carers, friends and family of people with a BPD diagnosis.

Kelly Vincent MLC, Dignity Party, Judy Burke, Dr Martha Kent, and members from Sanctuary BPD Carer Support

Profile - Prof Andrew Chanen

Optimism for future outcomes of people who live with BPD

Professor Andrew Chanen, head of personality disorder research at the Melbourne-based youth mental health service Orygen, has seen enough progress in borderline personality disorder [BPD] research and treatment over the past 25 years to be optimistic about the future. "I believe BPD is poised to enter the mainstream," he tells The BPD Advocate in the wake of delivering a keynote address at the National BPD Conference in Perth. "That would put it alongside the likes of schizophrenia, bipolar disorder, anorexia nervosa, and severe depression. And the evidence is very clear that it should be there."

There's a caveat, however. "It's not there yet," Chanen warns, before pointing to the major problem holding BPD back – and it's not public attitudes to people with BPD. "I think a lot of the problems that we think of as being part of BPD are actually caused by the health system. And you can quote me on that. That is to say, the health system very often harms people with BPD and BPD is unique in its capacity for people to be harmed by the mental health system."

"Generally, there's an incapacity within the health system to deal with difficult patients – and there's no doubt that people with BPD can be interpersonally difficult," he says. "Medical professionals often see the behaviour of people with BPD as willful, and lack an understanding that the person has not yet developed a repertoire of appropriate ways of relating to themselves and other people. So if patients are provocative these medical professionals – who are not used to seemingly ungrateful patients – will respond to the provocation in kind."

This, he believes, encourages the worst forms of behaviour in order for a person with BPD to get appropriate help. It also results in people with BPD being denied help until their problems escalate. For someone whose life's work has been built around the benefits of, and necessity for, early intervention in mental health, he finds this particularly upsetting.

"If you turn up to an emergency department and say 'I'm feeling really distressed' they will say go away, wait for six hours, and we might see you then," he explains. "If you then go out the front, smash a bottle and cut yourself and go back in you'll be triaged to a very high category. You'll get stitched but you won't get the distress addressed. So you will leave dissatisfied and still feel distressed. It is not surprising then that people will then go out the front, open up all the stitches and come back to the [ED] triage."

"So we set up all the contingencies to encourage people to get worse before we take them on and we don't address the primary concerns they might have, like stress, like a lack of employment. We focus almost exclusively on self-harm and suicidal ideation, and we don't address the things that are usually meaningful for the individual. I'm not saying we shouldn't address suicidal ideation and self-harm, but I think the story is more nuanced than 'self-harm is bad'. Plenty of people before me have said that

Prof Andrew Chanen

people harm themselves because it [helps them to manage their distress]. It's not the most adaptive way of coping [yet it works] and is better than not coping whatsoever."

A solution, he says, is a kind of early-intervention, educating trainee health professionals in how to respond to BPD

"And it's actually not that hard," says Chanen. "Once you stop fighting with these patients they actually are really enjoyable to work with. But you've got to train people [to better understand and learn about BPD] how to stop fighting and help support them. There's a way to go."

Underlining this point Chanen mentions how a group of 2017 medical students doing rotations in Melbourne had been taught by someone in their course that BPD was untreatable. "That was incredibly shocking and disappointing for me to hear," he says.

Chanen grew up in Melbourne and was strongly influenced by his father's work in the early intervention of cervical cancer. Later, when pursuing a research

Chanen (cont...)

degree on top of his medical degree, he met psychiatrist Pat McGorry and so began work on what proved to be the origins of the early psychosis program. "From then on I knew what I wanted to do and I went back to medical school, finished my degree, and geared everything toward psychiatry. I was interested in people and what makes them tick. It was then, and still is, the final frontier."

There is a solid body of evidence showing that treatment works – though he's quick to point out that there is no evidence to show that any one treatment is superior to another – and that "fancy psychotherapies" are less effective than structured, considered and consistent "non-punitive" care.

"What we need to do in the health system is less complicated than people think. We need to get our health system to respond appropriately at all levels and as early as possible to the problems associated with BPD and not to assume that this is an untreatable or a lifelong disorder. My belief is that it's the basic elements of care that matter and not doing harm is one of the principal ingredients of good care."

Finally, Chanen points to advocacy groups and families having played an incredibly positive role in raising and improving awareness of the disorder and he encourages them to "scream from the rafters" and knock on politicians' doors asking for a fair deal for people with BPD. "I think they are the strongest voice we have to change the system."

"Still in Australia in 2017, in most jurisdictions, BPD is a diagnosis of exclusion from the mental health system. That is totally unacceptable. It has to change."

MHPN BPD News

MENTAL HEALTH PROFESSIONALS NETWORK

The first webinar 'What is BPD?' in the 'Towards a National BPD Training and Professional Development Strategy' was held on Oct 31 and had over 5000 registrations! View Webinar at https://www.mhpn.org.au/WebinarRecording/90/What-is-Borderline-Personality-Disorder?

The next webinar in this Australian Governement funded series will be held early in 2018. Register at https://www.mhpn.org.au/upcomingwebinars

BPD Networks are open to all GPs, mental health professionals and agencies. Currently available in Melbourne, Adelaide, Sydney, and Ipswich/West Moreton, QLD. Contact Angela Miller on a.miller@mhpn.org.au to join a network, or start one in in your local area.

mhpn

Tips for Christmas

MIND AUSTRALIA OFFER THESE SUGGESTIONS TO MAINTAIN BALANCE

The everyday stresses of living with mental ill health, or caring for someone with mental ill health, can be magnified during the holiday period.

The interruption of usual routines can exacerbate feelings of isolation and loneliness; time can drag; and misunderstandings between you and those you care about can bubble to the surface.

Here are some insightful tips from a member of a MIND Carer Reference Group that might assist you to keep well over this period:

* Whatever your circumstances, try to find a bit of joy to counter the negativity and uncertainty in the world. Sometimes just allowing ourselves to acknowledge some goodness and positivity in our lives can be helpful.

* Try and make a point of self-nurturing and self-loving, even just for 15 minutes per day. Acknowledge that you are important. Try and be in touch with what makes you feel good, whether it's meditating, reading, going for a walk, taking time out for a coffee, reading the paper, or listening to some music. Do whatever feels right for you.

* Acknowledging that this might be a difficult time may help you to prepare for it. If you feel overwhelmed try creating structure: for example, plan ahead to go to the movies or to take a day-trip somewhere.

* For those who celebrate Christmas, keep in mind that a lot of the pressures revolve around being sucked into the vortex of the commercial world! Remember that this isn't the be all and end all. If you're in a position to be giving gifts, try and keep them simple: a home-cooked meal, or a letter/card expressing your loving thoughts and appreciation for a loved one is often more treasured than the sparkly stuff.

* If you're worried about a family get-together where there are pressures and feelings of unease, try some visualisation. Our carer expert likes to metaphorically surround themselves with a beautiful, shiny, brass coating - something that strengthens them from within and minimises the impact of the unhelpful comments, behaviours or pressures of others.

* Defining and discussing boundaries with your loved one can also be helpful if they are in danger of engaging in risky behaviours (such as drinking). Talking this over beforehand and discussing strategies for minimising harm could avoid potential mishaps.

This is an edited version of an article first published by Mind Australia in Community Mind Newsletter

SANE AUSTRALIA - LIVED EXPERIENCE ONLINE FORUM

'Is it okay to ignore Christmas?'

Join the discussion live on December 19th at 7pm EADT

The Forum will also be available after the live session so you can still read the comments of the participants.

Here's the SANE link:

https://bpdfoundation.saneforums.org/t5/Special-Events/Topic-Tuesday-Is-it-okay-to-ignore-Christmas-19-Dec-7pm-AEDT/m-p/355167#M5436

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