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BPD Webinar Series:
Towards a National BPD Training and Professional Development Strategy
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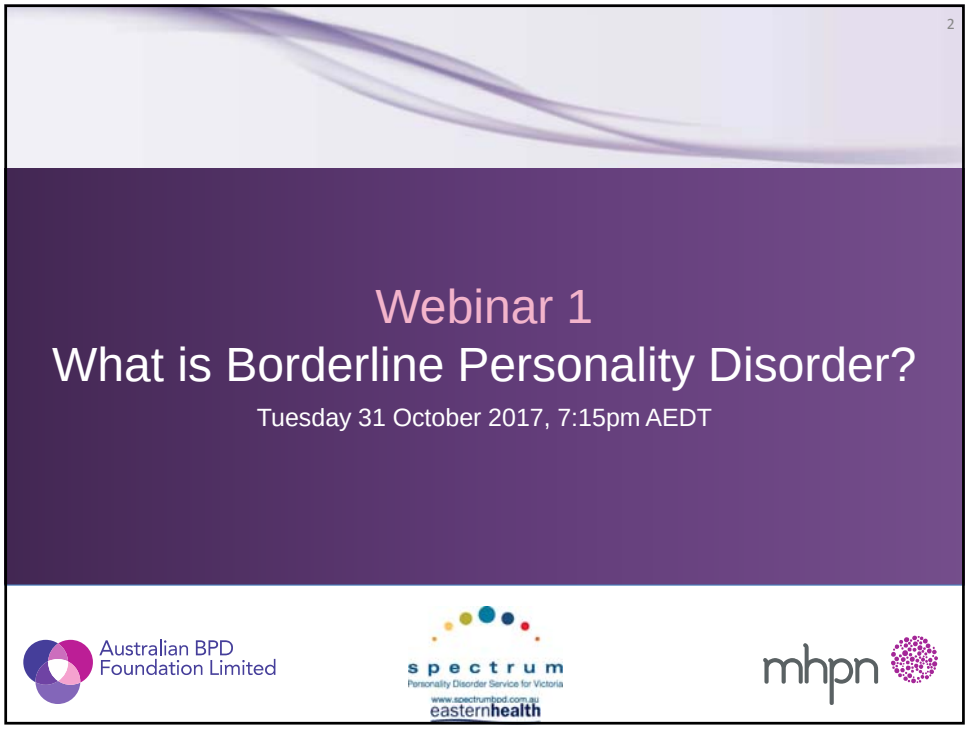
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Webinar 1
What is Borderline Personality Disorder?
Tuesday 31 October 2017, 7:15pm AEDT
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Tonight's Panel

A/Prof Josephine Beatson
Psychiatrist

Dr Christopher Wurm
General Practitioner

Janne McMahon OAM
Advocate

Julian Browne
Psychologist

Facilitator

Dr Lyn O'Grady
Psychologist

Audience tip:
To open the chat box, click the "Open Chat" tab located at the bottom right. The chat will open in a new browser window.

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Webinar Series

This is the first of six webinar for a National BPD Training project funded by the Australian Government. Other webinars in the series will cover:

Webinar 2: Management of self injury and suicidality
Webinar 3: BPD in youth and early intervention
Webinar 4: Treatment principles
Webinar 5: Management in mental health services, primary & private sectors
Webinar 6: Evidence-based treatments and access

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Ground Rules

To help ensure everyone has the opportunity to gain the most from the live webinar, we ask that all participants consider the following ground rules:

- Be respectful of other participants and panellists. Behave as you would in a face-to-face activity.
- You may interact with each other and the panel by using the participant chat box. As a courtesy to other participants and the panel, keep your comments on topic. Please note that if you post your technical issues in the participant chat box you may not be responded to.
- For help with your technical issues, click the Technical Support FAQ tab at the top of the screen. If you still require support, call the Redback Help Desk on 1800 291 863. If there is a significant issue affecting all participants, you will be alerted via an announcement.

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Learning Outcomes

Through an exploration of borderline personality disorder, the webinar will provide participants with the opportunity to:

- Identify borderline personality disorder and its underlying causes and describe appropriate assessment tools
- Outline how to discuss the diagnosis of borderline personality disorder with patients and their families
- Recognise prevalence of borderline personality disorder and understand stigma, shame and discrimination experienced by people living with borderline personality disorder.

Audience tip: The PowerPoint slideshow, Rachel's story and supporting resources can be found in the Resources Library tab at the bottom right.

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Psychiatrist Perspective

What is Borderline Personality Disorder

Borderline Personality Disorder (BPD) is a serious illness with the following core features:

- Difficulty controlling emotions and impulses
- Unstable and intense interpersonal relationships
- Unstable self-image (identity) and unstable sense of the identity of others
- Insecure attachment to significant others.

Suicidal and/or self-injurious behaviours often occur at times of stress, but tend to remit within a year or two of effective treatment.

BPD has a prevalence of 1-4% in the community; up to 30% of inpatients & 15-23% of outpatients in psychiatric facilities.

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Psychiatrist Perspective

What causes BPD

The aetiology of BPD is complex. It is the outcome of an admixture of inborn temperament, difficult childhood experiences, and insecure attachment.

- Inborn temperament in BPD tends to be oversensitive, anxious, & have a preponderance of negative, over positive emotions.
- Difficult childhood experiences can result from parents' difficulties soothing these babies. Invalidation of emotions and abusive experiences can also contribute.
- Insecure attachment in BPD manifests in severe anxiety about abandonment in significant relationships.
- **Childhood trauma and/or abuse is by no means always present.**

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Psychiatrist Perspective

When to consider a diagnosis of BPD

Consider BPD when one or more of the following is/are present:

- Frequent presentations to ED, primary health services, mental health services with self harming or suicidal behaviours.
- Frequent presentations in crisis situations with severe emotional distress (sadness, anger, unmanageable anxiety). Crises tend to occur in relational contexts or when abandonment threatens.
- Frequent occurrence of dysregulated emotional states and/or impulsive stress-related behaviours.

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Psychiatrist Perspective

Communicating the diagnosis of BPD

- Communicate the diagnosis only when you are sure about it.
- Describe the illness in terms of symptoms the patient has reported.
- Then name it, stressing that not only is BPD treatable, but that it usually responds well to treatment.
- Be sure to say that information about BPD on the internet is often misleading and/or inaccurate.
- Give the patient a written account of BPD or refer them to a reliable website (Spectrum, BPD Foundation, Project Air).
- Ask if they want to discuss the diagnosis with their partner/family/carer.
- If so, ask what help they would like from you in doing this.

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Psychiatrist Perspective

Treatment of BPD

- Psychotherapy (individual/group) is the principal form of treatment for BPD.
- It needs to be a collaborative endeavour, with an active therapist who is respectful, flexible, empathic, able to acknowledge own mistakes/misunderstandings and take responsibility for them.
- Validation of distress and a focus on the person's feelings/thoughts, at the time of self-harm or risk-taking behaviours is essential to progress and change.
- Consistent session times, duration, agreed goals, clarity about the treatment approach, clarity about responses to crises, are critical to treatment outcome.
- **The quality of the therapeutic relationship is the most important aspect of psychotherapy for BPD.**

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General Practitioner & AOD Specialist Perspective

- The outlook is better.
- We must update old, pessimistic definitions.
- People with BPD can be treated and it improves with time.

Christopher S E Wurm MB BS FRACGP FAChAM
Senior consultant, Sefton Park Primary Health Care Service,
GP Psychotherapist in Private Practice
Visiting Fellow, Discipline of Psychiatry
University of Adelaide

Dr Christopher Wurm

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General Practitioner & AOD Specialist Perspective

Taking a history from Rachel

- Goals: Build rapport & gain understanding
- Prioritise: What is urgent? What can wait?
- Set aside enough time (easier said than done)
  - See regularly – and allow time for emergencies
  - Have staff aware of emergency contacts and forms if involuntary admission is needed (rare but important)
  - Share the load
  - Supervision/de-briefing
- Listen more, talk less, but give feedback and hope
- Suicidal thoughts – current active plan?

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General Practitioner & AOD Specialist Perspective

When should Rachel talk about trauma?

- GP role is not about doing everything and looking for the underlying trauma all at once.
- Talking about trauma should only happen when:
  - You are feeling strong
  - You have already started psychological treatment and your problems and symptoms have improved
  - You trust your treatment provider. It is usually not helpful to discuss past trauma while you are in an emergency department during a crisis
- www.yourhealthinmind.org
  - https://www.yourhealthinmind.org/getmedia/e4a256bf-e2b8-4870-8ee5-54fd0a1d3acc/Borderline-personality-disorder-YHIM.pdf.aspx?ext=.pdf

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General Practitioner & AOD Specialist Perspective

Exploring co-morbid issues

- Rachel began experimenting with alcohol and pills at 14
  - "How many days a week do you use alcohol"?
  - "Do you ever have a bet on the horses, play poker machines or buy lottery tickets"?
  - "Do you use over the counter medications (codeine, Ford Pills, diuretics) or other people's medications"?
- Assess risk and consider harm minimisation
  - Thiamine, clean needle programs, Suboxone, methadone
  - Consider daily/weekly pickup from pharmacy to reduce risk of overdose of prescription meds, naloxone to reverse opioid o/d
- Eating issues
  - Self image, amenorrhoea, ECG, electrolytes, kidney function

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General Practitioner & AOD Specialist Perspective

Research, Success and Consumers' Wishes-Social Determinants of Health matter

"Users valued assistance with housing, finance, social networks, physical health and coming to terms with their problems, whereas professionals placed greater emphasis on the availability of professional support, treatment and monitoring."

Perkins, R. (2001). What constitutes success? The relative priority of service users' and clinicians' views of mental health services. British Journal of Psychiatry, 179, 9-10

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Advocate Perspective

Abandonment

- Expelled from school.
- After violent episode, parents refused to accept her home.
- Loss of significant friend.

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Advocate Perspective

Overwhelmed by emotions

- Hard to live with the pain.
- As teenager, unmanageable at home.
- Moves home frequently with frequent ED presentations.
- On and off with friends – drowns them.

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Advocate Perspective

Feels she doesn't deserve help

- Early years, disengages with case management.
- Sporadic attendance to counselling.
- Poorly engaged with case manager.
- Stays in violent partnership of 3 years – now looking to move in.
- Sexual assault, refuses to discuss with professionals.

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Advocate Perspective

Coping mechanisms

- Cutting
- Often takes overdoses
- Continues with risky behaviour

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Advocate Perspective

Stigma

- Hardest on people with BPD are themselves.
- Feels she deserves clinicians' stigma and discrimination and verbal putdowns.
- Finally the BPD diagnosis:
  - Worst thing: aware of consequences of diagnosis.
  - Best thing: a reason for her feelings, and actions.
  - Hope: now receiving appropriate treatment and support.
  - Consistent GP, psychotherapist and completed DBT course.

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Psychologist Perspective

How can we think of BPD?

- BPD thought of as 'developmental' in origin and a 'relational' disorder.
- Lack of caregiver attunement/validation or frank developmental trauma can result in personality structure developing as 'unstable'.
- Mind experienced as locked in emotion and memory – sometimes cut-off from bodily sensations.
- Symptoms of BPD can be thought of as adaptive and secondary.
- Person with BPD looks to the environment for stability and the signs of danger.
- Relationships experienced as potentially dangerous.

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Psychologist Perspective

The system

- Any work with Rachel must be wholistic; systemic and individual.
- The system, both family and health sector, will require 'treatment' prior to and during Rachel's treatment.
- Collaboration, effective communication, and ability to take all perspectives into account is essential to the success of Rachel's treatment process.
- This would be reflected in an inter-service treatment plan inclusive of Rachel and her family with a 'risk tolerant' approach.

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Psychologist Perspective

Treatment

- Direct treatment for Rachel must commence with a thorough developmental assessment using multiple sources.
- Thoughtful formulation with ongoing review would underpin both systemic and individual work and guard against burn-out and stigma.
- A focus only on symptom remission can lead to reactive and ineffective treatment.
- Non-reactive, proactive and longer-term perspective helps all treatment providers remain thoughtful and thus of most assistance to Rachel.

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Psychologist Perspective

Treatment principles

- Any treatment approach needs ongoing process of understanding and maintaining a collaborative relationship as its foundation.
- Autonomy for change needs gentle but continual returning to Rachel.
- Focus on putting words to internal experiences and use of language rather than acts leads to softening and decreasing severity of symptoms.
- Checking carefully for PTSD and obsessive symptoms important.

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Psychologist Perspective

Family

- Parents can experience considerable blame and stigma in health systems around BPD.
- Providing there is no perversity, parents can offer expertise and an important perspective; they will be around long after the clinicians have left the scene.
- Working with Rachel's parents separately is important, with possible family work to follow.
- Parents likely to experience guilt anxiety and anger/frustration along with grief associated with loss of the life they hoped for.
- Parents' input can greatly assist the work as they begin to collaborate with the treatment principles.

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Psychologist Perspective

Looking after yourself and the work

- Workers are exposed to a great deal of raw emotions from the client that can take its toll on us.
- All we have for the client is our ability to reflect, and when we are stretched, anxious or burning-out this function can be compromised.
- It is important to process that material outside the session to enable us to be available for the client therapeutically.
- We must be aware of our own limits and that of our roles to minimise over-reach and burn-out.
- Work structures that support thoughtful engagement are critical around BPD; advocating for this in the workplace is also advocating for the client group.

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Q&A Session





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Resources and further reading

Spectrum and The Australian BPD Foundation have put together a list of resources at

http://www.bpdfoundation.org.au/webinar-1.php

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Practitioner networking opportunities

Visit www.mhpn.org.au to learn more about joining your local practitioner network.

A number are being established to provide a forum for practitioners with a shared interest in BPD. Visit www.mhpn.org.au (news section) or contact MHPN to learn more.

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Thank you for your participation

- Please ensure you complete the *feedback survey* before you log out.
- Click the Feedback Survey tab at the top of the screen to open the survey.
- Certificates of Attendance for this webinar will be issued within four weeks.
- Each participant will be sent a link to the online resources associated with this webinar within two weeks.
- Next BPD webinar will be held in early 2018.

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Thank you for your contribution and participation

Good evening

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