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Lead or join an existing MHPN Borderline Personality Disorder network

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Register your interest

MHPN
WEBINAR

Thursday 13th April 2023

Borderline Personality Disorder: Translating evidence into practice

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Mental Health Professionals' Network

Tonight's panel

Sophie Lucas
Peer Worker/Educator
with a Lived Experience

Dr. Dianna Bartsch
Research Coordinator /
Clinical Psychologist

Prof. Brin Grenyer
Clinical Psychologist

Assoc. Prof. Sathya Rao
Psychiatrist

Facilitator:
Prof. Steve Trumble
General Practitioner

The webinar platform

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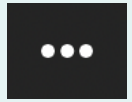

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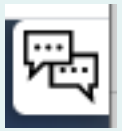

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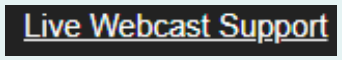

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Learning outcomes

Through an exploration of the latest research on evidence-based assessment, intervention and treatment strategies with a focus on how mental health practitioners can best support people living with BPD, the webinar will provide participants with the opportunity to:

- Outline the major themes and findings from recent research on Borderline Personality Disorder (BPD).
- Improve understanding of BPD presentations, stigma prevention, interventions and treatments.
- Identify evidence-based strategies for how health practitioners can effectively support people living with BPD.

A Lived Experience Perspective

Borderline Personality Disorder

- From a clinical perspective, BPD is comprised of 9 (main) criteria, and a person needs to meet at least 5 of those, for a diagnosis.

- This means there are 256 combinations of criteria for a BPD diagnosis.

From a personal perspective, I see this as we are all so different, and with that, comes a lot of strengths we all possess, and differences in what treatments may work best for us.

Sophie Lucas

A Lived Experience Perspective

Borderline Personality Disorder

People with BPD aren't manipulative…

We are:

- trying to get our *needs met*
- trying to problem solve
- trying to survive in a world that often isn't easy for us to navigate
- trying to protect ourselves
- using coping behaviours.

Sophie Lucas

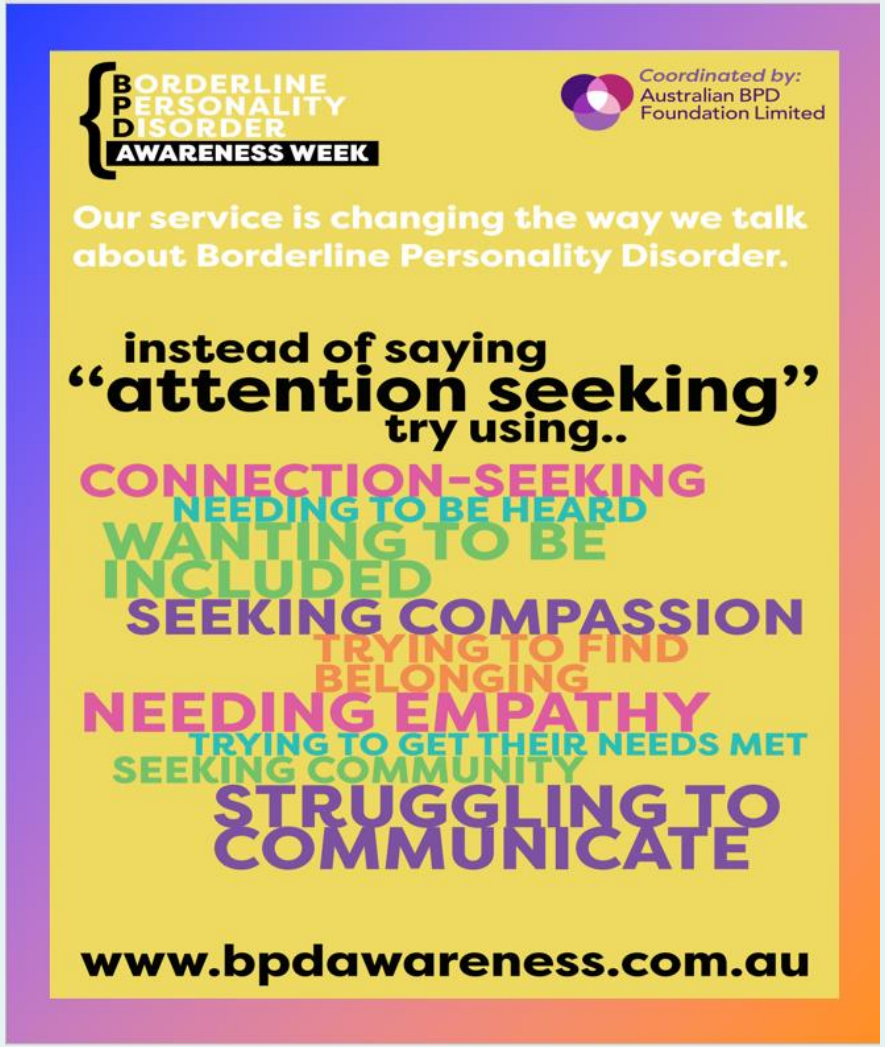
A Lived Experience Perspective

Borderline Personality Disorder

People with BPD aren't attention seeking …

We are:

- seeking connection
- needing to be heard
- trying to fit in and belong.



Sophie Lucas

A Lived Experience Perspective

Talking about Personality Disorder

Communicate about communicating

- Language affects people in different ways.
- Discussing the language that people with lived experience prefer is essential to a strong therapeutic alliance.

INAPPROPRIATE	WHY NOT THIS LANGUAGE?	PREFERED
The borderline, borderlines, being borderline	Reduces people to their diagnosis. Use person-first language that acknowledges the person as an individual human being.	• Person with: lived experience, with a diagnosis of BPD, living with BPD • You are not your diagnosis, but it can help you understand what is going on for you and what to do about it
Crazy, psycho, toxic, bad, schizo	May label a person in a stigmatising way.	• Experiencing difficulties and challenges
Overreacting, dramatic, irrational, overemotional	May invalidate how the person is feeling.	• Attempting to get their needs met • Sensitive, compassionate • Having a rough time
Calm down, get over it, snap out of it, go for a walk	Can reflect a simplistic, reactive or impatient view of a person's struggles.	• I can see that you are distressed • How can I support you? • What has supported you previously? • What would you need right now?
Manipulative, attention seeking, difficult, controlling, demanding, self-centred	Can reflect how *you* are feeling, and misunderstanding of the person's motives and behaviour.	• Connection needing • Trying hard to get their needs met • Showing a reflective compassionate tone rather than a reactive critical one
Should, could	Often followed by unsolicited advice. Hearing and acknowledging can be enough.	• I am here to listen/support • It is ok to have bad day • If you are not ready to talk to today, I am ready to listen when you are ready
Not trying, self-defeating	Reflects that you think that someone should be trying harder.	• Choosing not to... • Doing their best • Being unsure of what to do
Lost cause, treatment-resistant, won't get better, can't be helped	It reflects hopelessness. Hold hope instead and acknowledge someone's efforts and strengths.	• I believe you can recover • There is hope • You are resilient, strong • You have survived a lot • I can be patient and support you to try to work out what you want
Non-verbal language such as laughing at someone or disrespectful facial expressions.	It can communicate disrespect and misunderstanding.	• Align verbal and non-verbal language to communicate respect. • Making culturally appropriate eye contact. • Give a gentle look and compassionate eyes.

Sophie Lucas

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A Lived Experience Perspective

How to respectfully talk about diagnosis, treatment and recovery

Keep communicating…

- Not every time is the right time to talk.
- It might be helpful to put a conversation on hold, but make sure you follow up later.

DIAGNOSIS

See also the Fact Sheet "Giving a diagnosis of personality disorder"

- Use person-first language
- Talk with each other about how to give a name to the issues someone is experiencing as some people find the terms used in medical textbooks unhelpful
- Communicate a diagnosis verbally
- Be collaborative e.g. endorse diagnostic criteria together
- Invite questions
- Offer the diagnosis in a simple and direct, yet sensitive, compassionate and validating way
- Provide education about the diagnosis, treatment, recovery journey and support, *see for example the Fact Sheet "You've been diagnosed with BPD, what now?"*
- Recognise that a diagnosis is often temporary and that recovery is possible

TREATMENT

See also the Fact Sheet "Providing compassionate recovery-oriented care"

- Communicate about treatment in a collaborative, safe and supportive manner
- Discuss individually what language is preferred to describe treatment as the words treatment and evidence-based therapy are not helpful to some people
- Discuss what treatment means to the person

RECOVERY

- Discuss alternative terms for recovery such as recovering, journey, discovery or healing as for some people the word recovery is not helpful
- Make recovery collaborative, inclusive and be patient
- Communicate that recovery is different for everyone
- Recovery involves clinical recovery as well as personal recovery
- Discuss what recovery means to the person
- Communicate hopeful yet realistic information about recovery
- Recognise that recovery is not linear and that lapses may occur

Sophie Lucas

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A Lived Experience Perspective

Dialectical Behaviour Therapy

Practicing the skills that work for me, and not trying to do skills that don't work for me, is when DBT became more helpful, and a helpful part of how I live well with BPD

Sophie Lucas

A Lived Experience Perspective

What BPD looks like…

Sophie Lucas

A Researcher's Perspective

Stepped care treatment

- Specialised therapies for BPD effective in reducing overall borderline personality disorder symptom severity (Oud et al., 2018).
- Access to intensive evidence-based treatments limited due to duration, cost, length & intensive training for therapists (Choi-Kain et al., 2016; Iliakis et al., 2019).
- Stepped care (NHMRC, 2012, p 102) "*Beginning with the least intensive treatment that is likely to be effective, then monitoring response to increase or reduce the intensity of the intervention according to the person's need*"

Dr. Dianna Bartsch

mhpn

A Researcher's Perspective

Brief Intervention

- Audit of Coroner's records, among people with a diagnosis of BPD who died by suicide, 25% had presented to an ED in previous 6 weeks (Broadbear et al., 2020).
- Inconsistent responses to people with BPD in emergency settings (Cases et al., 2020)
- People with BPD benefit from psychoeducation soon after diagnosis compared to waitlist control (Zanarini et al., 2018; Zanarini & Frankenburg, 2008)
- Brief intervention (Gold Card – Project AIR) reduced BPD symptom severity & distress improved quality of life (Huxley et al., 2019)

Dr. Dianna Bartsch

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A Researcher's Perspective

Short-term therapy (< 3 months)

- Meta-analysis of psychological therapies less than 6 months duration - short term interventions *may* be effective (Spong et al., 2021)
- Less resource intensive therapies could be developed through integrating common factors from effective evidence-based therapies for BPD (Choi-Kain et al., 2016)
- Patients in both short-term (12 weeks) and extended care (6-24 months) clinics demonstrated improved outcomes (Laporte et al., 2018).
- **In progress**: Non-randomized clinical trial comparing naturalistic waitlist to intervention (Adult, Youth, Offenders, Rural & Remote).

Dr. Dianna Bartsch

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A Researcher's Perspective

Peer Group - Co-production Qualitative Interview Study

- **Growth & Change**: What I got from peer group
- **Connection & Feeling Understood**: How peer group helped
  - **Subtheme**: *Shared experiences*
- **Creating Safety:** The mechanics of group
  - **Subtheme**: *Equal footing*

Dr. Dianna Bartsch

A Researcher's Perspective

Challenging stigma

- Positive correlations between personality pathology and minority stress among Australian sexual and gender minority populations (Magann, 2022).
- Psychiatry trainees near the end of training had a significantly more negative view of patients with BPD compared to early and mid-stage trainees (Lindell-Innes et al., under review)
- 1-day Foundational training co-delivered with experts with lived experience improved clinician attitudes towards people with a diagnosis of BPD, particularly for those early in their career or where they had less clinical experience with patients (Wright, 2022)

Dr. Dianna Bartsch

A Researcher's Perspective

Key messages

- People with a diagnosis of BPD may gain benefit from structured psychological interventions spanning from 1 - 3 months while waiting for access to more intensive evidence-based therapies.

- It is important to engage people with a lived experience of BPD and their carers in training delivery and co-production of interventions

Dr. Dianna Bartsch

A Clinical Psychologist's Perspective

RESEARCH ARTICLE

Personality and Mental Health

To love and work: A longitudinal study of everyday life factors in recovery from borderline personality disorder

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Funding information
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Abstract

Although recovery from borderline personality disorder (BPD) is common, not all individuals improve over time. This study sought to examine the features that contribute to response or non-response for individuals at different stages of recovery from BPD over a longitudinal follow-up. Participants were individuals with a diagnosis of BPD that were followed up after 1 year of receiving psychological treatment. There were no significant differences between participants at intake across key indices; however, at 1-year follow-up, two groups were distinguishable as either 'functioning well' ($n = 23$) or 'functioning poorly' ($n = 25$) based on symptomatology and functional impairment. Participant qualitative responses were analysed thematically and via Leximancer content analysis. Thematic analysis indicated three key themes: (1) love of self and others, (2) making a contribution through work and study and (3) stability in daily life. Participants who were 'functioning well' described meaningful relationships with others, enjoyment in vocation, and described less frequent or manageable life crises. The 'functioning poorly' group described relationship conflicts, vocational challenges, feelings of aimlessness and purposelessness, instability in daily living and frequent crises. Leximancer content

Prof. Brin Grenyer

Grenyer et al 2022 Personality and Mental Health

A Clinical Psychologist's Perspective

7 steps for good enough therapy

1. **Stigma** can be overcome by being compassionate, responsive and **trauma informed –** which includes communicating the **correct diagnosis early** to improve understanding, treatment and recovery.
2. **Short term therapy has a place -** Well planned and systematic stepped care programs improve clinical outcomes, increase access and reduce costs and burden – communicate and agree on duration at the start.
3. **Focus on relationships** – inside (identity, self-compassion, therapy alliance) and outside (family, peers, employers) – be open to including others if helpful.
4. **Encourage agency in the here-and-now,** to recognise their capacity to make choices, and set short term goals to focus work.
5. **Be active in the therapy room** - help use the time to focus on the relationship between current challenges, actions, feelings and thoughts.
6. **Encourage safety, stability and predictability** - People do better in therapy if they can also maintain some stability in living arrangements, develop close relationships and engage in work or study.
7. **Talk about the progress of sessions** with a trusted colleague to calibrate your reactions and maintain a hopeful attitude.

Prof. Brin Grenyer

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A Clinical Psychologist's Perspective

Prof. Brin Grenyer

A Psychiatrist's Perspective

Borderline Personality Disorder

- Causation
- Diagnostic issues
- Biological approaches

Assoc. Prof. Sathya Rao

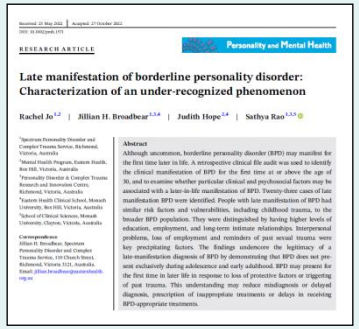
A Psychiatrist's Perspective

Age of onset

- BPD usually emerges during adolescence (Chanen, 2009, Zanarini 2001)
- One can diagnose BPD from age 12 (NHMRC Guidelines 2012)
- **BPD presents across life stages**
- Late manifestation of BPD (Stevenson 2009, Bernstein et al 2002, Zanarini 2007)


ANZJP

Missed diagnosis: The emerging crisis of borderline personality disorder in older people


RESEARCH ARTICLE

Personality and Mental Health

Late manifestation of borderline personality disorder: Characterization of an under-recognized phenomenon


CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF BORDERLINE PERSONALITY DISORDER

Assoc. Prof. Sathya Rao

A Psychiatrist's Perspective

What causes BPD?

Biological and psychological factors may be causal, with each person having a unique pathway to developing BPD

There is dispute regarding the relative contribution of these two factors.

Ref: Bateman and Krawitz (2013)

Assoc. Prof. Sathya Rao

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A Psychiatrist's Perspective

Biological factors

Abnormalities in brain (Hyperactive amygdala, limited cortical control of amygdala, anterior insula abnormality etc.)

50% heritability (Genetic Heritability Effect: BPD 55-68%- Torgersen et al 2000; Reichborn-Kjennerud et al 2013; Distel et al 2008)

5 times more chances if first degree relative with BPD

Assoc. Prof. Sathya Rao

A Psychiatrist's Perspective

BPD and trauma

- Trauma is very common in BPD and trauma informed care is essential
- **Trauma is a risk factor, but not essential for development of BPD**
- Trauma – correlation yes, causation no.
- Trauma in the presence of biological factors may cause BPD.

Assoc. Prof. Sathya Rao

A Psychiatrist's Perspective

Nature vs nurture

- Debate of nature versus nurture is out-dated

- Need to consider **"nature and nurture, nature via nurture, or nurture via nature".**

(Bateman and Krawitz 2013)

Assoc. Prof. Sathya Rao

A Psychiatrist's Perspective

Co existing conditions

"BPD is the King of Comorbid Kingdom" (P. Tyrer)

Co-occurrence is the norm rather than exception

Only 5% present in pure form

- Depression
- Substance abuse
- CPTSD
- Eating disorders
- Other Personality disorders
- ADHD
- Autism
- Bipolar disorders
- PTSD
- OCD
- Anxiety disorders
- Schizophrenia
- Dissociative disorders
- PCOS
- Chronic Pain

A Psychiatrist's Perspective

Co existing conditions (cont'd)

- Psychiatric disorders that coexist with BPD do not respond to medications robustly unless BPD is treated with psychotherapy.

- Where BPD co-occurs with another disorder, the best outcomes occur when both disorders are treated concurrently.

Assoc. Prof. Sathya Rao

A Psychiatrist's Perspective

Biological approaches to BPD

No medications are patented or indicated

Very limited evidence for Lamotrigine, Topiramate, Omega 3 Fatty acids and Quetiapine (crisis management)

Electro Convulsive Therapy (ECT) and Transcranial Magnetic Stimulation (TMS) don't work for BPD even if BPD co-occurs with Depression

Assoc. Prof. Sathya Rao

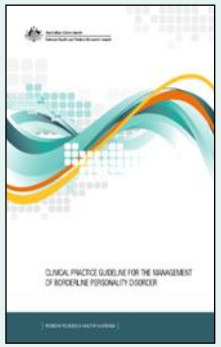
A Psychiatrist's Perspective

The take home message..

"Having BPD is not the persons' own fault.

It is a disorder of the brain and the mind."

(National Health and Medical Research Council 2012).



Assoc. Prof. Sathya Rao

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A Psychiatrist's Perspective

The take home message..

"As long as you don't judge, as long as you try to validate the valid, and as long as you can tolerate emotions (yours and theirs) and teach them skills to improve their quality of life, you can contribute to their recovery journey"

Give it a go!

(Joel Paris)

Assoc. Prof. Sathya Rao

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Q & A

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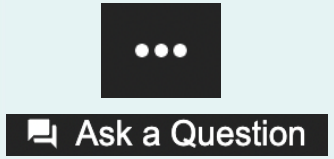

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