Book Club: The 'Handbook of Good Psychiatric Management for Borderline Personality Disorder' – a practical handbook indeed

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Host (00:01):

Hi there. Welcome to Mental Health Professionals Network podcast series. MHPN's aim is to promote and celebrate interdisciplinary collaborative mental health care.

Dr Rick Yeatman (00:17):

Hello everyone, and welcome to another episode of MHPN Presents: Book Club. My name's Rick Yeatman, I'm a Melbourne psychiatrist, and with me today is Dr. Paul Cammell, who's also a psychiatrist from Melbourne.

Dr Paul Cammell (00:30):

Pleasure to be here.

Dr Rick Yeatman (00:31):

Well, it's great for us both to be here, Paul, we've done this before. We did a Book Club, which really was a chat about psychotherapies, and what all that means. And it was based on a book by a guy called Jerome Frank, called Persuasion and Healing, and I recommend people to have a listen to it because we thought it was great fun.

Dr Paul Cammell (00:53):

Good conversation.

Dr Rick Yeatman (00:54):

And I think that we discussed some pretty interesting topics during that session. Today we've got something kind of linked. We're doing a book called The Handbook of Good Psychiatric Management for Borderline Personality Disorder by, the main author is a guy called John Gunderson, and he's with another fellow called Paul Links. I think they're both American, is that right?

Dr Paul Cammell (01:23):

They certainly are.

Dr Rick Yeatman (01:24):

And this book came out in, I think it was the early, 2014, I think it was?

Dr Paul Cammell (01:30):

2014, I think.

Dr Rick Yeatman (01:33):

Yeah. But this kind of came, it was a distillation of lots of writing this man's done, but we'll come to that in a minute. Before we dive into it, I want to say part of the reason why I chose this book and Paul agreed to do it was that, first of all, I think borderline personality disorder is a very interesting topic, especially the treatment, the therapeutics, and a lot of staff spend a lot of time talking about this particular condition, and a lot of people admit quite freely that it's something that they struggle with, in helping these people with this problem. So, we thought it was a good one for an audience. Let me just tell you about the book. The first thing is it's short.

Dr Paul Cammell (02:16):

It is a short book, isn't it? Deceptively brief and concise.

Dr Rick Yeatman (02:20):

It's got a total of 67 pages of text about the topic, which is not very many considering when you see most books about psychotherapy, in particular, are usually fairly lengthy. It's got 72 pages as well of case illustrations, case studies, which is quite interesting. And it's got 12 pages of appendices, of which I think it's got two little appendices, which are quite useful. One is a kind of brief outline of what a safety plan is, and another one is a kind of an information sheet for families, which I thought were good additions. Before we go on further, I was thinking, Paul, the name Gunderson is really associated with this area, and you've specialised in this area to some extent. What can you tell us about the author?

Dr Paul Cammell (03:07):

So, Gunderson's really a titan of the field. So, the borderline term really emerged in psychoanalysis and psychiatry in the fifties and sixties. And I studied and trained with one of the central figures in it,

becoming quite prominent from the 1960s, Otto Kernberg. But Gunderson is a psychiatrist associated with Harvard and the McLean Hospital, did some of the key papers to really describe borderline personality disorder in the mid 1970s. So, make it, kind of legitimise it as a psychiatric diagnosis. So, then it appeared for the first time as a diagnosis in the DSM III in 1980. And from that time, there are a number of key works and publications that he introduced throughout the 1980s, '90s, 2000s around how to treat the disorder, how to describe it, and how to research it. So, through the nineties there've been a proliferation of lots of specialised therapies, but he's maintained this central line of trying to, in a sense, simplify and make more mainstream the diagnosis and the treatment of the disorder. So, he's remained this central figure all the way through, really promoting understanding and advocating for people to engage in treating the disorder.

Dr Rick Yeatman (04:23):

Yeah, so have you ever actually seen him speak, or?

Dr Paul Cammell (04:27):

I have. I've seen him in workshops over in the States, and sadly I tried to get him over here for a workshop. He passed away a couple of years ago, and his health was failing, so it was hard to get him over to Australia, but I've seen him before.

Dr Rick Yeatman (04:43):

Okay, so you would've heard a lot of this before, when he speaks. I just want to make a comment, and I made a note about this, what the book's not about. Obviously this is a very big topic with a long history, a lot of classificatory debate, a lot of different views about the way you approach these people, but what this book doesn't have in it is really much of that stuff. It doesn't have a lot of the background theory. It doesn't have really, I don't think it's actually got the diagnostic criteria in there anywhere. It doesn't go into really any summary of the major research. There's a little bit, but not much.

Dr Paul Cammell (05:21):

That's right. It's not a big swollen theoretical treatise, or lots of research, is it. It really simplifies things, and talks about an approach, doesn't it? A clinical application.

Dr Rick Yeatman (05:31):

That's right. Okay. I think we'll go through some of the chapters, anyway, because they've each got a kind of a theme. The introductory chapter is, really, Gunderson trying to tell us why he wrote the book, and where this concept of a good psychiatric management for borderline personality disorder comes from. So, first of all, he says that about 2% of people in America have borderline personality disorder. And I guess if we say that about Australia, we're talking about half a million people, which is a lot.

Dr Paul Cammell (06:05):

It's a lot of people.

Dr Rick Yeatman (06:06):

It's a lot of people.

Dr Paul Cammell (06:06):

Oprah did a show about borderline personality disorder, so the equivalent over there we're talking about three to 5 million people, and it was kind of like they're all out there, what do we do?

Dr Rick Yeatman (06:16):

And if Oprah brought it up, it must be an incredibly important topic.

Dr Paul Cammell (06:20):

Exactly right.

Dr Rick Yeatman (06:20):

He also says that he doesn't believe his therapy is psychotherapy. He calls it case management. And Paul, would you like to comment what, I found it difficult to differentiate those two concepts, because case management's always had a vague meaning anyway, so.

Dr Paul Cammell (06:36):

I think this book came at a time when, I think I alluded to before, there's been this proliferation of therapies, specialised therapies, dialectical behaviour therapy, mentalization based treatment, transference focused psychotherapy, that are quite specialised, and people had the perception in mental health that you needed a lot of training, you needed to be a specialist and only these types of practitioners could treat borderline personality disorder. He's trying to demystify it and say that you don't necessarily have to be a specialist psychotherapist, there are other contexts in which meaningful therapeutic work and clinical work can occur. So, he deliberately says it's not another psychotherapy, it's something that's broader and more applied, that can fit into other contexts and settings, which is a really important message to convey, because if you've got these ideas like in Australia, half a million people or in America, a few million people, you can't build an army of specialist psychotherapists. And there's this funny paradox between the idea that people are knocking at doors thinking I need to find a therapist, I need to find someone. And they're actually, along the way, people suffering from this disorder, seeing a lot of people along the way. So, if you can actually mobilise the GP, you can mobilise the community mental health team, you can mobilise the generalist psychiatrist to be skilled up and to engage in a meaningful way, that's actually going to be therapeutic and helpful.

Dr Rick Yeatman (07:58):

Yeah, there's two things there. One, just on your point of who can do this therapy, he makes it clear that a psychiatrist can do it and they can also prescribe, but he also says that any other non-prescribing mental health worker can use this therapy. They may have to rely on a doctor to do prescribing if it's indicated, but it's certainly not aimed at just doctors.

Dr Paul Cammell (08:20):

Well, that's right. And so, I guess when we hear the term case management, we are imagining a community mental health team where there might be a team involved, there might be the psychiatrist, there might be the case manager or key clinician doing this, and we've seen that in inner Melbourne, Royal Melbourne, we've done that, haven't we, we've applied this kind of approach.

Dr Rick Yeatman (08:38):

I think, just the term case management, just to stick on that for a sec, I finally found what he actually defines as case management in the book. It's on a table actually, it's not in the text, and it's being focused on life outside the therapeutic frame as well. So, it's not that other psychotherapies don't do that, but he's suggesting that this is why you can call it case management rather than psychotherapy. So, therefore, it doesn't come with all the baggage that the term psychotherapy brings with it. Okay. I want to get onto how he devised this. He mentions that in a lot of the big studies comparing the valid effective psychotherapies for borderline personality disorder, that the control groups receive some form of therapy, which is often found to be pretty effective. And one of those studies was actually done in Melbourne. It's a study done by the origin team, which I was fascinated. I actually heard them talk about it, but I didn't realise that, when you think of the bigger picture, that this is part of Gunderson's thinking. Anyway, so he did a study and Paul, do you want to talk about that, where there was comparison between this therapy and DBT, which is dialectical behaviour therapy?

Dr Paul Cammell (09:52):

Well, that's right. And there are comparable results, essentially. And he, at the time, I think called it general psychiatric management. So, it was kind of like a beefed up version of treatment as usual, where people are getting meaningful treatment. And so, it's different to being on a waiting list, and he was comparing that type of treatment, which subsequently has become this good psychiatric management, with dialectical behaviour therapy and the results were comparable.

Dr Rick Yeatman (10:17):

Yeah, it was interesting that the original study and the one that he cites was a slightly different therapy, and that went for a year. This one, he's saying there's no particular timeframe.

Dr Paul Cammell (10:26):

He's trying to make it more flexible.

Dr Rick Yeatman (10:29):

He also says the big difference in this one, he's added that people should focus a bit more on the person's vocation and what they do with their life, because he feels that that's an area where, even if people do improve with borderline personality disorder, that lags in terms of their wellness, if you like, or their recovery. So, that's kind of the intro. So, it's meant to be a good enough treatment that people can learn and use, and feel confident that it's got some validity behind it in terms of its efficacy. So, that's all terrific. So, now we come to-

Dr Paul Cammell (11:06):

So far, so good.

Dr Rick Yeatman (11:07):

So far, so good! Now we come to the principles, and it seems that, I reckon he's got two underlying principles in this. One is that for these people, most of their problems can be explained by the borderline concept itself. And if you break it into the four main elements of borderline personality disorder, is the emotional instability, the impulsiveness, the impaired or negative self image a lot of these people have, and the one that he puts most emphasis on is the highly emotionally charged interpersonal situations these people get into. And I guess his concept is that it is often those interpersonal events that lead to the decompensation, and the really aberrant behaviour, and the self-harm and suicidality, which everyone knows about.

Dr Paul Cammell (12:13):

Making that a focus of treatment, interpersonal sensitivity, and often the other features can be really preoccupying for the individual and the treater, whether they're suicidal, or they've done something quite worrying or destructive, or they feel absolutely terrible in themselves, but linking it to what's going on in the person's relationship world and their relationships can be very, very important and meaningful in the therapy.

Dr Rick Yeatman (12:38):

So anyway, the principles he talks about, and he's got eight of them, and I'm just going to list them off, we haven't got all day. There's a page on each of them in the book, it's a lot to read. It's about five pages to read, this section. So, the first principle is the whole principle of psychoeducation, and he actually has a chapter on that which he calls, if I can find it. It's called Diagnosis, the chapter, but the psychoeducation, we may as well do that now, Paul.

Dr Paul Cammell (13:09):

It's kind of important, isn't it? A lot of practitioners will wonder about, do I name it, or do I make the diagnosis? And we know in lots of contexts, BPD is underdiagnosed. I was involved in doing a bit of an audit in South Australia, and we got the boffins at the health department to tell us how many presentations they'd been to emergency departments in a year, and they went away for a couple of weeks and came back and said 17, for a whole year. And we kind of know that that's grossly inaccurate, because people aren't making the diagnosis. So, he really demonstrates a way to approach making the diagnosis, and educating a person in a way that's demystifying and not in any way about stigma.

Dr Rick Yeatman (13:50):

He actually has a table of the pros and cons of discussing the diagnosis, and what it means. And fundamentally the answer is, well, the person then knows what you think. They make up their own mind whether it fits them. And often, people do think it does fit them when they understand what it is, but then you're able to explain the reasoning for the type of treatment, and be able to explain that certain

treatments has been shown to work with this condition, while others haven't. So, that's a big part of it. And he talks about psychoeducation for the family as well.

Dr Paul Cammell (14:28):

He emphasises positive expectations, doesn't he? The sense that it's treatable and understandable, and there are measures that can be made that actually can work towards a person recovering significantly, rather than it being a doomsday kind of diagnosis.

Dr Rick Yeatman (14:42):

He does have the stats about recovery, and how many people get better after a year, and five years, and 20 years, I think it is. So, it's telling the person that this is what you got, the mystery is over, and this is what can be done for it. So, that's his view. And I suppose I agree with that. I mean, I think how you go about treating someone without telling them what it is, even if you had a knee injury for example, and the person mysteriously wanted to do things to it and you didn't really understand why, I mean, some people would go along with that, but most people wouldn't. They'd want to know, why are we doing this particular thing?

Dr Paul Cammell (15:21):

That's right.

Dr Rick Yeatman (15:23):

Alright, okay. He says, number two is, that the treatment must be active. In other words, it shouldn't be reactive, it should be with a plan with the person to make progress. So, it's not something you sit there and just wait for things to happen. You actually get there and roll your sleeves up. He says the therapist has got to be a thoughtful person, reflective, cautious, not knowing everything and admitting that, and this, he says, is a direct way of helping the person learn about not being black and white in their thinking. I'm interested in your view on that one.

Dr Paul Cammell (16:02):

Well, that's right. I think all of the specialised therapies, and Gunderson distils them down very accurately, and he talks about what he's taken from all of these specialist therapies like transference focused therapy, mentalization based treatment and DBT. And yes, an active, curious, interested, boundaried therapist who acknowledges their own fallibility, assumes a reflective, not knowing stance, and wants to warmly engage with the person in a noncritical, non-judgmental way and also pays attention to the structure and the contracting of the therapy, and limits to what they can do as well. So, not setting themselves up to be everything, and working very collaboratively with the person as well, but having clear goals and a clear structure to the work as well, and making it very clear what the person is doing and what they aren't doing in the frame.

Dr Rick Yeatman (16:56):

Yeah, okay. Be real, is number four. And fundamentally he says, be able to acknowledge mistakes, and to not encourage unreal expectations.

Dr Paul Cammell (17:10):

That's right. Interpersonally sensitive people are very good at picking up if you're trying to pull the wool over their eyes, or be deceitful or duplicitous about something. So, being honest is very important.

Dr Rick Yeatman (17:21):

He even touches on, a little bit of self-disclosure doesn't necessarily hurt. It makes you probably more trustworthy in the person's eyes. Expect change, so don't just drift along. He makes it very clear that if the treatment's not working, it's not working. And unless you can think of approaching it from a different direction, you've got to acknowledge that. Don't just drag things on.

Dr Paul Cammell (17:47):

Well, that's right. And I think the positive message in that is also if the treatment's quite active, and it's goal orientated and recovery orientated, there's actually this idea that that's empowering for the person as well. They're not getting a negative message that they need to be taken care of, or they're going to be necessarily chronically impaired or disabled. There's a lot that they can take control and responsibility for, with support and with a collaborative approach. And that's a really positive message to give someone.

Dr Rick Yeatman (18:14):

He next talks about holding the person accountable for their own role in the therapy, which is sometimes hard to do. Some people find that difficult. I think all doctors are kind of trained not to think like that.

Dr Paul Cammell (18:28):

To take care of people, be the doctor.

Dr Rick Yeatman (18:32):

To take care of people, yeah. And he makes this a point, so that the person, you talk about the person's own accountability for their own reactions and responses and behaviours and things, which is probably something which could be challenging for some people, for others, not so much. To focus on life outside the therapy, this is the thing he added in from the original study he did, and that's because of, the evidence is that it's these life functions which are often lagged behind the improvement with people with borderline personality disorder, such as getting a job or getting back to school or whatever it is. And he last says, be flexible. So, these patients or people can throw up lots of challenges and things, and so you've got to know when to be a bit more supportive, or a bit more kind of, perhaps, problem solving and things like that. It's interesting, Paul, and one of the things, you read a lot of books on borderline personality disorder, and they have about, 50 percent of it is about countertransference. He hardly even mentions the term.

Dr Paul Cammell (19:39):

That's right. It's implicitly mentioned, in the fact that he's got a very reassuring and optimistic style in the work, and talks about the challenges, but he addresses right at the beginning of the book, in the introductory chapter, the types of prejudices that clinicians can have about difficult patients, angry all the time, not really wanting to engage in treatment in a healthy way, all of the things that might be a part of a countertransference response, where you feel frustrated, angry, fearful or anxious as a practitioner. So, he kind of reassures the practitioner with those common elements of what can occur when you're engaging someone with borderline type issues. And he acknowledges that he gets a lot of the working with one's own counter transference from the Kernberg tradition, the transference focus tradition. But he doesn't talk a lot about it in a psychodynamic sense in the book, how you're constantly thinking at that level of the relationship as transference and countertransference. But he's very reassuring in how he talks about in a practical sense, and that's reflected in how he talks in the first half of the book, and then all of the case examples, how a person can kind of deal with the challenges, and the curve balls, and the things that would elicit counter transference.

Dr Rick Yeatman (20:54):

Yeah, he does. I think that it's always fascinating to read about that topic, but if you get too bogged down with it, it seems to be all you can think about. Well, he does paint a picture that, hey, there's a group of people out there, they're struggling, like a lot of people, with their mental health and we've got to get a bit more confident about helping them.

Dr Paul Cammell (21:14):

That's right.

Dr Rick Yeatman (21:15):

And I think that's a nice message. I mean, we've all had our buttons pressed by someone with a borderline personality disorder, and you learn a lot about yourself, over time, trying to help these people.

Dr Paul Cammell (21:28):

It challenges our sense of why we do our work, and how we want to feel about the work that we do, and we can feel anxious, powerless, affronted at times, doing this work. And it's important to be in touch with that, and work out that that's a part of the relationship. And actually, it can build a much healthier way of engaging with your work, if you are much more in a kind of humble, collaborative, actively engaged, in a way that you're empowering your client or your patient. It's a good message.

Dr Rick Yeatman (21:59):

Just to think of clinical work, I mean often a lot of us, especially if you've worked through the public system in our initial years, will often see these people at their worst.

Dr Paul Cammell (22:09):

That's right.

Dr Rick Yeatman (22:10):

So, they're in the emergency department in an acute inpatient unit, they're often really emotionally lost control, and decompensated. I suppose, and I don't know, getting on in years, I've met lots of people with this disorder. Obviously most people, most of us have, and I find that most of them are actually quite engaging people most of the time. When things aren't really bad, then they can be really challenging, but they're actually people you can work with. And I think that we've all been blinded about what we've seen in our early experiences, I think.

Dr Paul Cammell (22:46):

That's right, and that's what I try to instill in myself and anyone that does work in acute settings, whether it's inpatient or emergency departments or crisis teams, is that idea that you try to overcome your own anxiety or avoidance, or your own strong reactions to what the work might be, and actually just try to form that real connection. And he talks about that active, authentic kind of connection. So, even if you've got someone that's in a very unstable, agitated state in the emergency department, and there's a lot of people reacting negatively to them being there, actually some of the real answer to that situation, for the service and the context and the individual, is engaging with them in a meaningful way, and just settling down the situation and collaborating with them, even if it's whatever needs to happen, actually that's the key ingredient.

Dr Rick Yeatman (23:33):

I mean, I know we're not meant to talk about things outside the book, but I want to just mention a little thing that I've kind of been thinking about a lot in recent years, and I talk to people with this problem about it, and it's about emotions. And if you have a line, at one end is a robot, and the other end is an incredibly highly dramatic human being, now all of us are somewhere on that line. So, I don't see, it's more that what you've got is humanness, gets dialed up too much in people with borderline personality disorder, their human emotions are too strong, their sense of what is life is too strong. Their sense of who am I is too strong compared to most people, but it's not actually a thing that's abnormal, it's just more intensified. And a lot of people, if you point out that it's probably better to have emotions than to be a robot, which don't have any emotions, is not such a bad thing. It's just a question of keeping them under control.

Dr Paul Cammell (24:34):

That's right.

Dr Rick Yeatman (24:35):

Anyway, enough of the issue of his principles, and people can read about them. I've tried to remember all eight of them. I can't, but I kind of understand them all. I think if we talk about his diagnosis, look, there's a couple of things I wanted to throw at you, Paul. He's pretty clear that when you talk about the diagnosis and the condition, that he believes that you'd tell people that about 55% of what they're

feeling is in their genes, and the rest is probably environmental. I mean, I haven't read the pure science behind all this, but is that actually accurate, or is it, it's just a kind of guess?

Dr Paul Cammell (25:14):

I think that's a reasonable way of approaching it and looking at it. There's no single etiology or cause, there's lots of associations with disrupted early development with different forms of complex trauma such as neglect, childhood abuse of different kinds. There's also difficulties in familial relationships and blurring of intergenerational boundaries. But there is also, it's well understood that there's a huge constitutional component around negative affectivity, and emotional regulation, and those kinds of things. So, they're all bundled together. So, I think appreciating the complexity of it, and that there is a mix of environmental and constitutional factors, and not getting hung up on one particular cause is a really good way of dealing with it.

Dr Rick Yeatman (26:05):

Yeah, it's interesting. I forgot to mention in the intro that there's a couple of videos you can go to. They're pretty old and blurry now, and I watched them, one of them, the person acting or the patient who's pretending to be a patient or whatever, is saying how, that their problems will relate to their childhood trauma. And the therapist is actually saying, well, yes, yes and no. Your parents may have struggled with you a bit because of the way you were, your temperament as well. So, it's not just that black and white. And I found that quite interesting, because it was obviously very confronting for the person. They felt that their trauma was being devalued. And the therapist actually was able to talk them around and get them to understand. But it was very interesting. I don't know, I don't know if you've seen the video.

Dr Paul Cammell (26:59):

Yeah, I have. And there's a big overlap, there's no doubt about it, with the association of different kinds of complex trauma with BPD, but trauma isn't necessary or sufficient to cause, if you like, a borderline syndrome. But there's a multitude of different factors that come together to create these kinds of issues. So, I think that's the way to look at it. So, trauma needs to be validated, but also other elements of the situation, and the problems that the person have need to be thought about as well.

Dr Rick Yeatman (27:33):

Yeah, okay. Alright. He then gets down, in the next chapter, to getting started, and basically, he says that once a week is probably his ballpark.

Dr Paul Cammell (27:44):

Good enough.

Dr Rick Yeatman (27:46):

Yeah. And how long it goes for depends on how a) successful it is. So, if it's working, great. If it's not working, well then maybe you've got to think of something else. He also talks about the issue of, and this is a tricky one and I want to get your view on this, how accountable is the therapist for things that

happen outside the therapy, and what should one, talk to the, how should one talk to the person that you are treating about things that happen at three o'clock in the morning on Saturday, after you've been to the disco or whatever.

Dr Paul Cammell (28:24):

This is a huge part of the work. And often, and I know this through my public work and my private work, that can often precede even engaging the person. There can be other stakeholders contacting you. There can be letters, there can be reports, there can be all of this anxiety about who's going to contain this situation, or who's going to do what. And a lot of the initial phase of engagement, yes, there's the assessment and psychoeducation and therapeutic alliance building, but there's a lot of attention paid to contracting, and the frame that you're working with, and what you're doing and what you're not doing. All of the therapeutic approaches, Gunderson's and all of these other specialised therapies, talk about that. And there's lots of different rules, and they're all also related to the context that the person's in, and that you practice in as well, that I think the common message is a lot of thought needs to be put into that.

(29:16):

My colleague who I trained under in New York, Frank Yeomans, his first whole book was about contracting in this space. So, actually spending a lot of time talking about if and then, and who does what. And I think that message needs to be applied wherever you work, that you need to really specify what you're available for and what you aren't, because there's so much sensitivity there that can be triggered by not knowing, or reaching out for you when you're not available. All of the abandonment, all these sensitivities. So, you need to be quite clear about, I do this when I'm in private practice, this is how you contact me, this is how I'll get back to you. This is what you can expect, this is what I can't do. And in these other situations, all of these other situations, this is what you might do. So, some of that's about safety planning, but it's also about creating a network of support that's consistent and explicit around the person. And that can also involve other stakeholder engagement like family and carers, other people like the GP, because everyone will want to know as well, if this person's risky, they'll want to know what to do, and when and how.

Dr Rick Yeatman (30:18):

Yeah. So, he makes, that that's part of getting started. So look, you mentioned the word contract. Now, I found there was a little section in this book which I really, really liked reading about, was when he talks about how you develop an alliance with someone, and he breaks it into three sorts of an alliance. So, everyone can have a breather from borderline personality for a minute. And just, the concept of-

Dr Paul Cammell (30:41):

Talk about alliance.

Dr Rick Yeatman (30:42):

Alliance. And the first one he talks about is contractual alliance. So, this is when you sit down with the person, and you set the goals and the frame of the relationship, and obviously these type of things, about what happens outside of therapy if problems arise. So, that's the contractual alliance.

Dr Paul Cammell (31:00):

Yes.

Dr Rick Yeatman (31:00):

He then talks about relational alliance, and this is where people possibly use terms like empathy, and therapeutic rapport, and those type of terms about how you can develop an alliance by the person trusting you, or feeling you're genuine, or feeling that you're interested in them and you actually have the same feelings towards them as a person that you are trying to help, and going to put effort into their life.

Dr Paul Cammell (31:25):

And you've got some optimism that the relationship could be helpful.

Dr Rick Yeatman (31:28):

So, there's contractual alliance, relational alliance, and then working alliance. And this is what he describes as, how you can work through the little irritations, misunderstandings, et cetera, et cetera, that can occur in any interaction with another person. So, this is getting down to business, and two human minds clashing together and working together. So, I found that as a really neat little way, I wish someone had told me that years ago,

Dr Paul Cammell (31:59):

And it's a really good way of articulating something, again without making it too complex in the sense of psychotherapy and therapy skills and those kind of things. As I hear it, I think about how that translates into different psychotherapy models, but this articulates it very kind of cleanly and simply, doesn't it?

Dr Rick Yeatman (32:18):

Yeah, I think it's a really nice little thing. I think people should put that in their back pocket as just a way, when you're setting up working with somebody, it doesn't matter whether the person, you're seeing them for more supportive things or whatever. It's a nice little way of thinking.

Dr Paul Cammell (32:32):

And having a focus on maintaining the alliance, making sure the relationship's on track, and that is about looking at how the contract's going, are we actually working in that way. How's our relationship going, and little bumps or disruptions, are we ironing them out?

Dr Rick Yeatman (32:47):

Yeah, okay. I think the next few chapters, I'm not going to go into depth, they're very interesting. The first one is on suicide and self-harm, really obviously a big one, and it's the front of everyone's mind when people are trying to help people with borderline personality disorder. The next one is on pharmacotherapy, and I've got a couple of little comments I want to make about that. And the last one

is on split treatment, he calls it split treatment, which is sharing the treatment with other people. So, it could be group therapy, family therapy, someone prescribing, whatever, and he's got some things to say about that, but fundamentally he says, go for it.

Dr Paul Cammell (33:26):

Go for it, communicate, all be on the same page, and try to integrate it as much as possible, rather than have it things split in another way where people are at cross purposes, or antagonising one another in what they're doing.

Dr Rick Yeatman (33:40):

He even has a nice little paragraph or two on, if you're a non prescribing therapist, what to do if the prescribing doctor's kind of getting out of control.

Dr Paul Cammell (33:49):

That's right, the person's on five meds, and...

Dr Rick Yeatman (33:51):

So, I just want to talk about the suicide bit first. I mean, look, he talks about the statistics of self-harm and things, and he talks about various strategies, and not necessarily going to help the person, but ask them how you can help them. So say, I've got to care for you now, no. You say, how can I help you through this? So, he just gives some little kind of sentences you can use when in a situation. He also talks about the aftermath, and how after a suicidal period, it's a really good opportunity to do a kind of chain analysis of what happened, and try and get past the point of, I just felt like this, I lost it, to what might have pushed you into it, what thing was happening in your life?

Dr Paul Cammell (34:44):

And it's fascinating, sometimes there's a glaring divide there. You might have someone that's presenting in suicidal crisis, and you can look at the context and there's been something that's happened, whether it's a therapist that they've been seeing has left, or there's been some kind of loss or rejection or abandonment in the person's life, or some other stressor. But often when they're in front of you, they're saying, it's not that, or I can't feel any emotional connection to that, when they're talking about their crisis, and how to kind of think around that, and chain analysis or just close kind of reflection with the person about the steps that took them into this kind of crisis point can be very, very helpful.

Dr Rick Yeatman (35:26):

He also talks about people wanting to go to hospital when the therapist doesn't think it's ever been helpful, and he gives you a little spiel. You can say if you want to about how, in your opinion, maybe it won't be that useful, but let's work together on trying to work out what's the best way forward, kind of thing. So, I thought that was an interesting one for the people working in the kind of more acute end of the service, where they see the suicidal people in crisis. It was a good little passage.

Dr Paul Cammell (35:58):

It's a really nice demonstration of how to engage someone in those settings, as well.

Dr Rick Yeatman (36:03):

Look, we're going to have to get cracking here, Paul, but I wanted to talk to you about something: comorbidity. Now, you know and I know that you look up the discharge summaries of someone who's in ED for the fifth time in the last two years or whatever, and you'll find that, I reckon this is the list, it goes: depression, anxiety, bipolar, schizoaffective disorder, post-traumatic stress disorder, emotionally unstable personality disorder, and alcohol and drug abuse. Now, this is not a diagnosis, that's a diagnostic smorgasbord.

Dr Paul Cammell (36:44):

Often with a header like "situational crisis".

Dr Rick Yeatman (36:48):

Situational, or...

Dr Paul Cammell (36:49):

Self-harm.

Dr Rick Yeatman (36:50):

And people tend to choose one or the other of those, and kind of focus their treatment on that particular thing. It might be depression, for example, or it might be post-traumatic stress disorder, might be an eating disorder. He doesn't really talk about comorbidities at all. I mean, have you got any thoughts about that?

Dr Paul Cammell (37:09):

He puts BPD front and centre and talks about the rationale of treating the BPD. And as we all know, and he knows very well, that pretty much everyone with a BPD diagnosis has a comorbidity, and he lists them in a table at one point, but he makes the BPD the focus of the treatment, and there's some expectation that some of the other comorbidities might improve along the way, as you're treating with this focus. And that's where he mentions pharmacotherapy as being an option as well, for anxiety and mood issues and those types of issues, that the comorbidities will be taken care of as well.

Dr Rick Yeatman (37:51):

Well, he does make a point, he's got an interesting chart, which I hadn't seen before, which was, he talks about the comorbidities as the most likely to respond to, actually, management of the borderline personality disorder. And he feels that depression, panic disorder, and bipolar too will respond best to treatment of the borderline personality disorder through therapy, rather than medication. While mania, alcohol and drug problems, and anorexia nervosa may not necessarily respond as well to just pure

borderline personality disorder management. So, that's his theory. Just very briefly on pharmacotherapy, he borrows an algorithm for prescribing in this area. I don't think we've got time to go through that.

Dr Paul Cammell (38:37):

No.

Dr Rick Yeatman (38:38):

Okay. Paul, summing up, what were your thoughts overall of the book, obviously you're different to me, I kind of went into it without knowing much of Gunderson's previous work, but what are your thoughts of it?

Dr Paul Cammell (38:54):

This is a book that's really mainstream central approach to applying management of BPD in a range of different settings in general psychiatry and in community mental health, and the way that the therapeutic approach and the management is described as very elegant, accessible, coherent, and very applicable. And I encourage people to read the book. It's been a part of a movement to try to generalise principles of therapy to a lot of different settings. So, Gunderson took the charge with that, but all of the therapy schools like DBT, transference focused psychotherapy, schema therapy, mentalization based treatment, have all done this as well. They've all said, well, how do we apply these principles in the real world, in the emergency department, in the inpatient unit, in the community mental health setting? So, he kind of led the charge with that and a lot of these other groups have done that as well.

(39:57):

I think what he's done is very important, because what we are thinking increasingly nowadays over the last 10 years, is how everyone can do their bit. So, what a GP can do, what an emergency mental health clinician can do, what a community mental health team can do, and broadening out the principles. So, Gunderson's done that in other publications. One thing I would say about this book is that an ambitious community mental health team, for example, could take on this book and think, well, we can do this. Still, sadly for us in Australia, there are lots of community mental health teams that can't offer someone a weekly structured session, or regular input from a psychiatrist. So, when you read, which was half the book, the case examples, you think, well, they could be a bit scary or complex for a psychiatric resident or registrar.

(40:52):

If it was a non-medical clinician, having access to a psychiatrist to coherently follow through this approach might be challenging in some sectors. So, I think this is best practice, to have a community mental health team that sees BPD as a core business, and can do this kind of approach. And as he says, because we know in the past, certain community mental health teams might try to get a DBT group going or something, and there'd be waiting lists of two years for all of these people that need it. If all community teams can do something like this, but also be a bit flexible about it and do it in a staged way. So, they do do bits like a bit of assessment and engagement. They do offer some split treatments, so some groups, they can offer some form of case management like Gunderson describes, or they can

integrate and liaise well with other treaters like general practice and private clinicians out there, psychologists and psychiatrists, we can get things to work a lot better. So, he's done a really good job of showing how treatment can be more integrated.

Dr Rick Yeatman (41:54):

Wonderful. Well, we're just about running out of time, I think. So, we definitely both hope you enjoyed our conversation about the Handbook of Good Psychiatric Management of Borderline Personality Disorder by John Gunderson and Paul Links. And if you want to learn more about this topic, or about ourselves, our bios are found on the landing page of this episode. We also find a link to a feedback survey, and some more information if you require. We don't have time now, but I was going to get Paul to talk about some other books he could recommend about this particular topic. Perhaps if we just put that on the landing page, that may be better.

Dr Paul Cammell (42:36):

Send you some resources.

Dr Rick Yeatman (42:39):

Yeah, for those who want to dig a bit deeper. But thanks for listening, I hope you learned something, I certainly did by reading this book and talking about it. And I do find it very, very useful with, when you're reading rather dense mental health textbooks, to be able to actually chat with someone else about them, because you can talk about things that inspired you, that confused you. So, I think it's a great forum. It's goodbye from myself, Rick Yeatman, and...

Dr Paul Cammell (43:10):

It's goodbye from me, and it's been a wonderful conversation. Thanks a lot, Rick.

Dr Rick Yeatman (43:14):

Thank you very much, everyone.

Host (43:15):

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