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Webinar

An interdisciplinary panel discussion

Borderline Personality Disorder: Working Together Working Better

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Wednesday 13th April 2011

"Working together. Working better."

Supported by The Royal Australian College of General Practitioners, the Australian Psychological Society, the Australian College of Mental Health Nurses and The Royal Australian and New Zealand College of Psychiatrists

This webinar is presented by

Panel

- Dr Christine McAuliffe (Brisbane based GP)
- Dr Andrew Chanen (Melbourne based psychiatrist)
- Dr Chris Lee (Perth based psychologist)
- Janne McMahon (Adelaide based consumer advocate)

Facilitator

- Dr Michael Murray (Townsville based GP and medical educator)

This webinar is hosted by

- A Commonwealth funded project supporting the development of sustainable interdisciplinary collaboration in the local primary mental health sector across Australia
- Currently supporting approx. 500 local interdisciplinary mental health networks meeting face to face across Australia
- For more information or to join a local network visit www.mhpn.org.au

Learning Objectives

At the end of the session participants will:

- **Recognise the ways in which clinicians and/or treatment teams may be challenged when providing mental health treatment and care to borderline personality disorder presentations**
- **Acquire strategies to build individual and/or team resilience**

To find out more about your disciplines' CPD recognition visit www.mhpn.org.au

Session outline

The webinar is comprised of two parts:

- Facilitated interdisciplinary panel discussion
- Question and answers fielded from the audience

Session ground rules

- The facilitator will moderate the panel discussion and field questions from the audience
- Submit your question/s for the panel by typing them in the message box to the right hand side of your screen
- If your specific question/s is not addressed or if you'd like to continue the discussion, feel free to participate in a post-webinar online forum on MHPN Online
- Ensure sound is on and volume turned up on your computer. If you are still experiencing difficulties hearing the panel, call the telephone number provided in the message box to the right hand side of your screen.
- Webinar recording and PowerPoint slides will be posted on MHPN's website within 24 hours of the live activity
- For further technical support call **1800 733 416**

What makes people with BPD tick?

Having BPD is not deliberate; people do not choose to have it

- Constant internal pain or feeling absolutely nothing
- Unable to trust
- Anger
- Heightened overwhelming emotions
- Life in turmoil

What do you see - how are behaviours challenging?

People that you don't particularly like, people you feel compassion for or people who are a challenge?

- Self-harm
- Threatened suicide
- Missed appointments - then needing instant access
- Lashing out
- Anger
- Other health issues

Why do people act this way?

People do whatever they need to in order to –

- Ease the constant internal pain or actually feel something
- Lessen overwhelming emotions
- Regain sense of order
- Feel back in control

How will you respond?

Avoid perpetuating fundamental feelings - evil, abandoned, invisible, ignored, alone

- Empathy
- Understanding
- Firm but compassionate boundaries
- Recovery dependent on choices

Three messages to take from a consumer perspective

- People do not choose to have Borderline Personality Disorder
- People do whatever they need to do in order to survive
- People do recover

Borderline personality disorder

1. **Affective instability**
2. **Inappropriate anger**
3. **Chronic feeling of emptiness**
4. **Stress-related paranoid ideation/dissociation**
5. **Identity disturbance**
6. **Impulsivity**
7. **Recurrent deliberate self-harm**
8. **Unstable relationships**
9. **Avoidance of abandonment**

4 core clinical dimensions

- **Affective or emotional dysregulation**
- **Cognitive**
- **Behavioural dyscontrol or impulsivity**
- **Interpersonal**

BPD is a major public health problem

- **Approximately 320,000 youth and adult Australians have BPD**
- **1.5 – 3% population**
- **>20% psychiatric outpatients**

BPD is a major public health problem

- Severe functional impairments
  - More stable than the BPD diagnosis itself
- High risk of suicide
- Negative effect on the course of depressive disorders
- Extensive use of treatment
- High costs to society

Personality problems usually become apparent in adolescence or emerging adulthood

- Acknowledged in DSM since 3rd edition
- Demographically crowded period of life (Arnett, 2000)
- Potential for ensuing developmental disruption high (Skodol, Pagano, et al., 2005)

Early intervention for BPD is possible

- **"Proof of concept"**

Chanen et al., British Journal of Psychiatry 193, 477 (2008)

Chanen et al., Australian and New Zealand Journal of Psychiatry 43, 397 (2009)

Not all patients who provoke you have BPD!

Assessment

- Distinguishing ‘state’ from ‘trait’
  - Evidence of the problem outside of periods of mental state disorder
  - Usually present for at least two years
- Interested in the way a person is *usually*

Treatment is effective

- Several specific forms of psychotherapy appear to be beneficial for at least some of the problems associated with BPD
- No evidence to suggest that one specific form of psychotherapy is more effective than another

Pharmacotherapy contraindicated as a primary treatment for BPD

- Poor evidence for the effectiveness of pharmacotherapy for BPD
  - Should largely be avoided
  - Polypharmacy
- Might be indicated for co-occurring syndromes

General principles across successful treatments

- Access to services
- An understanding of BPD (a model)
- Comprehensive assessment
  - Including co-occurring problems
- Non-judgemental acknowledgment and acceptance of individual's experience, wants and needs
  - "People with BPD are doing the best that they can manage"

General principles across successful treatments

- Open, empathic and collaborative relationship
  - Optimism
  - Autonomy and choice
- Structure and consistency
  - Not reactivity to crises or self-harm
  - Managing transitions and endings

General principles across successful treatments

- Attend to case management needs/care planning (including safety plan)
  - Clear delineation of roles & responsibilities
- Attend to co-occurring psychopathology

General principles across successful treatments

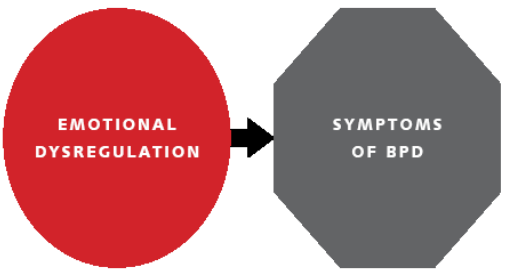
- Common team approach
- Supervision and team support

General Psychiatric Management (Gunderson)

- Weekly individual meetings
- Focus on person's priorities
  - Not necessarily targeting self-harm and suicidal thinking
- Psychoeducation about problems
- Here and now focus
- Emotion focus
- Relationship focus
- Hospitalisation not always contraindicated

Evolution of Dialectical Behaviour Therapy

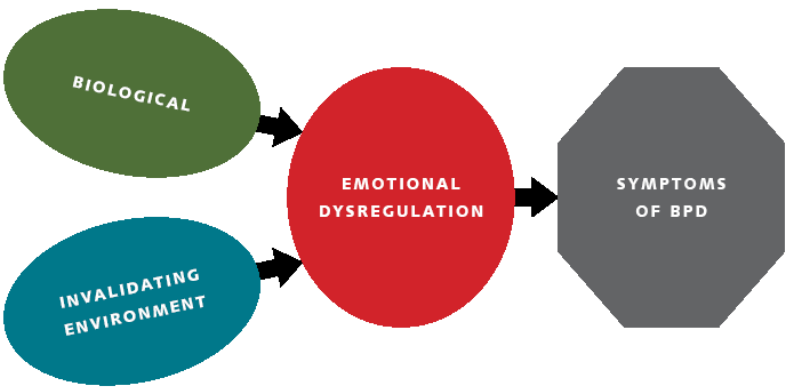
- DBT began as Behavior Therapy
- Added validation
- Add Dialectics
- Add Mindfulness



Mechanism of emotional dysregulation in BPD

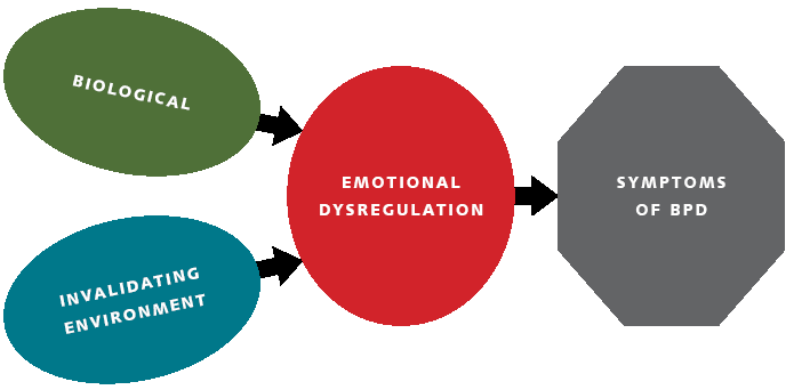
1. Biological
   - some evidence genetic link
   - intrauterine

2. Invalidating environment



van der Kolk

- Amygdala inhibits pre-frontal cortex and hippocampal functioning
- Largely mediated by noradrenalin
- Effects include hyperarousal, conditioned strong emotional responses to neutral stimuli, and interference in development of life skills



Invalidating environment.

Defined as

one in which communication of private experiences are met by erratic, inappropriate, and extreme responses

Examples

- erratic responses
- sexual abuse

Some effects of invalidation

- No label for emotional experiences
- Teaches self-invalidation
- Extreme displays of emotion rewarded
- Encourages emotional inhibition
- Reduced sense of self

Emotional Dysregulation

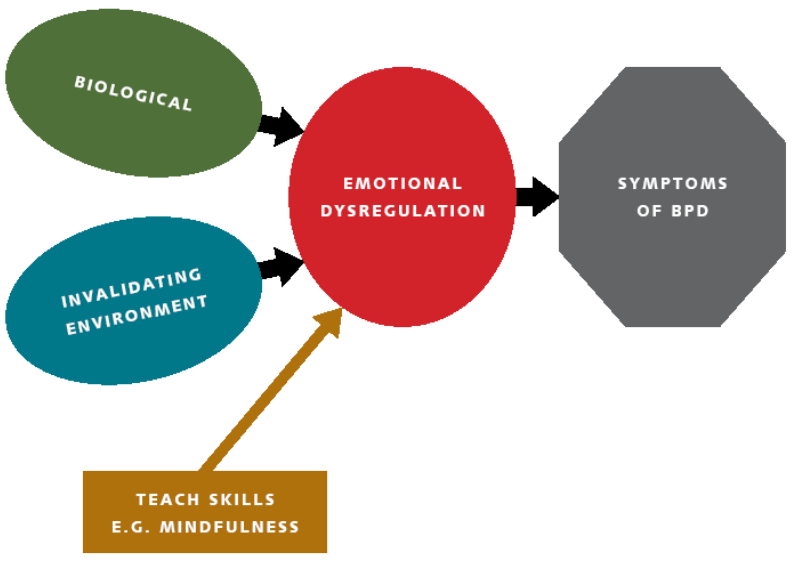
- very high sensitivity to emotional stimuli
- very high re-activity
- after arousal, slow return to baseline

Emotional Dysregulation

- Inadequate emotional regulation leads to problem bevaviours
  - inhibit inappropriate behaviour
  - refocus attention in presence of strong emotion
  - self soothe
  - organise self for action

Purpose of Emotion Management

- Decrease or increase physiological arousal associated with emotion. Re-orientate attention.
- Inhibit mood dependent action. Experience emotions without escalating or numbing.
- Organise behaviour in the service of external goals.

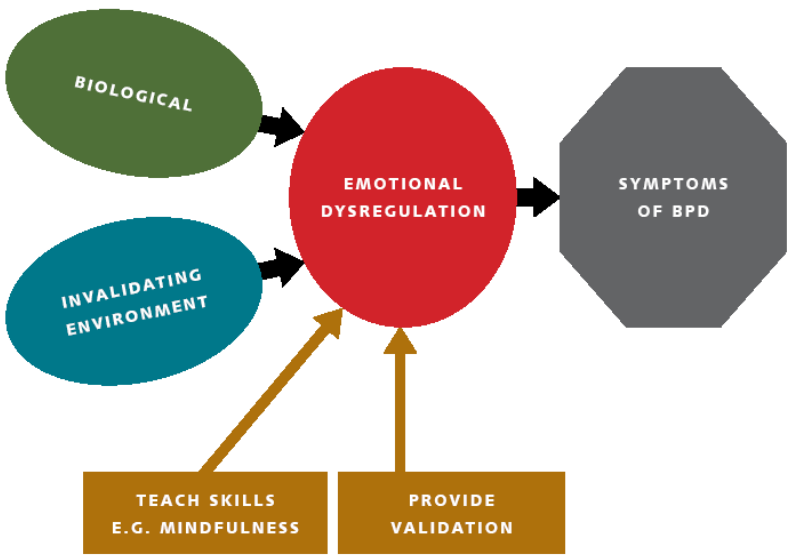


Linehan (DBT)

a) Ongoing assessment, specify treatment goals

b) Skills training

1. Mindfulness
2. Emotional regulation
3. Distress tolerance
4. Interpersonal skills



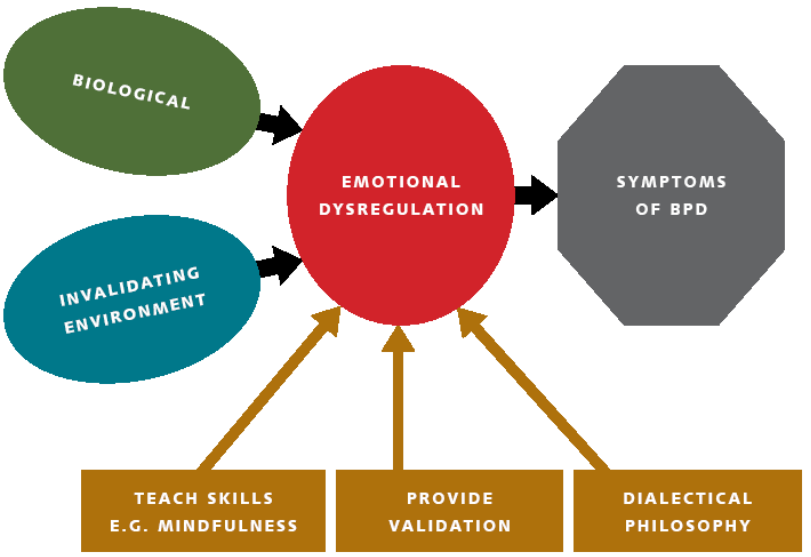
Linehan (DBT)

a) Ongoing assessment, specify treatment goals

b) Skills training
1. Mindfulness
2. Emotional regulation
3. Distress tolerance
4. Interpersonal skills

c) Validation (radical) of client's behaviours

d) Special attention to therapist relationship



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How will you respond?

BPD will often result in “challenging behaviours”

- Professional level
- Practice level
- Distressed family and friends

The GP perspective

- Acknowledge the distress triggering the behaviour
- Seek to strengthen their coping repertoires
- Structured problem solving
- Setting reasonable limits for them and yourself

The GP perspective

- Acknowledge that their safety is in their hands
- Negotiate agreement to a crisis plan that is shared with other members of team, and family/carers if appropriate

The GP perspective

- Maintain professional relationship – beware of your emotional response to their challenging behaviours
- Give a sense of hope but don't fall into the trap of "rescuer"
- Work as a team and seek support - "first rule at traffic accident"
- Take a long term perspective

Thank you for your participation

- Please complete the exit survey before you log out
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