BPD: Multidisciplinary strategies to navigate feelings of rejection and fear of abandonment

Disclaimer: The following transcript has been autogenerated and may contain occasional errors or inaccuracies resulting from the automated transcription process.

Prof Steve Trumble (00:00:00):

Good evening everybody, and welcome to all of you who have joined us for tonight's webinar and also the viewers who are watching the recording at some later date. I'd like to begin by acknowledging the traditional owners of country throughout Australia and recognise the continuing connection to lands, waters and communities. I wish to pay respect to elders past and present. I acknowledge the memories, traditions, cultures, and hopes of Aboriginal and Torres Strait Islander people. My name's Steve Trumble and I'll be facilitating tonight's session. I'm a GP by background, currently professor of general practise curriculum and workforce at Deakin University in the western district of Victoria. We've got a great panel tonight. So, the bios were disseminated before the webinar with the invitation to join, so I won't go through them in detail, but we do want to meet them to find out who's going to be sharing their expertise and sense of teamwork tonight. So first off, most importantly is Chloe. Now welcome Chloe. I should explain to our participants or our audience that you have chosen not to show your image tonight. So there's nothing wrong with people's equipment, but you can be heard. So Chloe, you've mentioned in your bio that you work to support young people and their mental health. So what do you find particularly rewarding about this role?

Chloe (00:01:28):

From a lived experience point of view, being able to work with these young people. It's, it reminds you of a journey that you've been through yourself, so being able to talk to them as real people, getting to understand them even if we don't really understand them, but letting them know that somebody's listening to them, that's the most rewarding. And being able to build a rapport with them, it's incredible how far that can get them and giving them the opportunity to be able to grow up and be able to share what's going on for them and being treated like humans.

Prof Steve Trumble (00:02:05):

Fantastic. Well it's so good to have you tonight and we expect to hear a lot from you about your perspective, so that's great. We'll keep moving around the group now and the next person we'll be hearing from Zonia Weideman there from Queensland. Now Zonia, you were involved with implementing a virtual care initiative there in Ipswich. So can you tell us how this has helped consumers?

Zonia Weideman (00:02:31):

Yes, it was a great honour to actually establish a team that specialises in the treatment of people living with a personality disorder and embedded within this team was a consumer portal, so this enabled people to access their care teams, including their care, their peer workers via multiple methods, for example, chat function, video conferencing, and it just provided people an enhanced experience with their care team. A formal evaluation was completed that included consumer

interviews and the consensus was that the consumer portal ensured that consumers received the right kind of treatment at the right time, which we were very proud of.

Prof Steve Trumble (00:03:11):

That's fantastic. It's a great outcome. So great news. And now we'll move to the third person will be hearing from tonight. So Sathya, welcome. I'm sorry, I should say I'm going to ask you a question. That's right. Why are you so passionate about working with people who live with borderline personality disorder?

Assoc Prof Sathya Rao (00:03:31):

Steve, thank you. Say people borderline personality disorder are some of the nicest people I have met in my profession and I find them very, very forgiving. I tend to goof up things, I tend to make mistakes. They're very forgiving and most of all they get well all the time. And for a psychiatrist that is extremely gratifying.

Prof Steve Trumble (00:04:00):

That's great. And as you say, quite rare to have that degree of forgiveness and something to be treasured. So that's wonderful and people should know that Chloe is grinning like a Cheshire cat at that thought of forgiving the psychiatrist, which is great. So we've got a good team today. I've got somebody with lived experience, an occupational therapist and a psychiatrist who specialises in this field. It's going to be a good discussion and we'll make sure we leave plenty of time for your questions and for discussion between the panel members. Towards the end, I will just take you through the interface just in case people are having problems with it already. I think we're on a new system, CrowdStrike or something it's called. It was a very bad joke. We've got a really robust system here and we won't be crashing. Everything will work really well I'm sure.

(00:04:50):

So with the web player, please make sure that you access the various resources. You can see the button down there in a handsome teal green colour view supporting resources. You can also see where you complete the feedback survey on the way out. But before we get there, the supporting resources have got everything from the case study items that the panellists thought you might get some benefits from as well as the slide deck that we're using tonight. You can also see up the top right hand corner of your screen there is the stream chat with that speech, but we'll talk right hand corner, click on stream chat and you're about to join the group and the chat discussion where there are people introducing themselves. Nadia is having a problem with sound, so me saying this won't help her, but there is unfortunately a sound icon you might have to click on to get the sound to work, but she won't hear that.

(00:05:48):

So if somebody might be able to text her that in the chat, that would be fantastic. If you do have tech support, there is a tech button you can click to get help. But the very first thing is that if the webcast appears to have frozen for you, please try refreshing your browser. So highlighting and clicking enter and you'll reload the webcast and hopefully it'll all work again. Sometimes people's internet's a bit slow and the computer just gives up, so that's a good way to start. But if you can't get it going again, click on tech support to get some help. And that's in the top right hand corner up there near the chat group. There it is. Or tap tech support next to the panellists listing there. Now

with the chat group, please make sure you are respectful of each other participants and the panellists and keep comments on topic as much as you can.

(00:06:44):

Going off on a tangent can just be distracting for others who are trying to focus more. If you can add to the conversation through the chat, that's fantastic. Now what's happened tonight, we've got three panellists, which is a good number because it means that we'll have plenty of time for conversation towards the end of the webinar. Each panellist will give a short five minute presentation about their discipline and then it'll be followed by questions and answers between the panel. The learning outcomes are there and you can see what they are. I won't read them. It does take time that we could be using, but the one I wanted to point out particularly is the third one. We want to look at how a multidisciplinary approach can support people living with borderline personality disorder to better manage their feelings because when people feel they've been abandoned, that's not the case when there's a network of support and people are often just moving further through the system.

(00:07:42):

So we'll talk about that in some detail. I did want to point out though the disclaimer, which is really quite important, tonight's about education there people are not speaking as clinicians or providing advice in this role. We're talking as educators talking about clinical experience and personal experience, but not giving clinical advice. And if anybody does find the content distressing, because this does happen, we all have issues that can be triggered sometimes by what's discussed. Please seek care from who you would normally seek care from, your gp, local mental health practitioner or service or call Lifeline, but it's always important to look after yourselves. So hopefully the equipment's working, it seems to be, which is great. We will get on with the presentations and most appropriately we're going to start with Chloe. So please, Chloe, take it away.

Chloe (00:08:44):

Thank you everyone. So yeah, just wanted to start off with what it is to identify treatment strategies that support people living BPD to better manage their feelings of rejection and fear of abandonment. From a lived experience perspective, for me the communication was key. So often in my own mind I'd be looking for evidence of fear of abandonment. So even simple things such as a text message with a full stop on the end, just having that full stop could trigger this fear. Or if someone went through a door and closed it behind them, to me that was a sign of abandonment. So being very, very hyper alert and sensitive to all of these triggers. And sometimes I recognise it was very difficult for people to be able to know what they'd actually done. So being able to unpack that after to have a chat about it so that there was clear communication, oh, I put a full stop because that's how I normally type messages.

(00:09:58):

It's not because I don't like you or I wasn't interested in what you were saying or I wanted you to stop messaging. So these are just some of the things in terms of clarifying actions, if there does seem to be a misunderstanding. And also another strategy would be setting clear boundaries. So being able to negotiate, being able to talk to the person with BPD who may be struggling with understanding what these boundaries are because there's always that element of, oh, I need to just make sure that they really care. So if just say you've set a boundary that please don't call me up 10:00 PM at night, people may call at five past 10 just to make sure that you really do care. But just reconfirming these boundaries and being able to follow through with these boundaries. So it's hard

sometimes and you may say, oh, just let them talk. It's okay. But being able to say, hang on, I've mentioned that it's past 10 o'clock now so I won't be able to talk to you. How about you call tomorrow? So just being very clear with those things. Next slide please.

(00:11:15):

Now in terms of identifying strategies to educate carers and families to better support people manage this fear of abandonment and rejection, a key area is to approach the conversations at an appropriate time. So just say the person with BPD was highly stressed out, like in this case study, if Leah was very triggered and then you try to reason with her, often it just doesn't go right at all and it can end up getting worse. So just to wait till the person has cooled down, being able to reason with them. And often we do say to strike when the iron is cold, so when things are heated, when the moment's hot, just being able to know that that's probably not the best time to have a conversation. And then to be able to have that clear understanding and to be able to discuss what has happened with them and maybe to even set some boundaries.

(00:12:22):

So yes, people with BPD, they might push against the boundaries, but really these boundaries do keep them safe. There is an element of security when they know what to expect with these boundaries. And another support is definitely empowerment. So within the mind of a person with BPD, there's just so much going on emotionally that they feel out of control. They often feel that they need to hold onto something. So being able to give them choice then empowers them so that in their own mind, emotionally they may be out of control, but at least it gives them a bit of control with what's happening in terms of whether it's a conversation, whether it's where to meet somebody, just basic elements of control. Next slide please.

(00:13:14):

Now moving on. This one's a very important one. In terms of how I was supported as someone with BPD, the multidisciplinary approach. So with me, I had a case manager, but even within the case manager there were other supports put in such as having a peer worker. So throughout my supports I did have a peer worker who I could talk to and just have those real life lived experience chats about mental health and also I also had a psychosocial worker to support me when things were difficult just to be able to get out. As well as I had a key clinician, an MBT psychologist as well as a second psychologist who didn't focus on MBT but focus on other elements of recovery and being part of the hospital system, it made it a lot easier because I didn't have to repeat my story again and again.

(00:14:22):

So you can imagine that's one of the worst things when there's so much trauma already to then see a different person every time and repeat the story again. So just having that whole team around the person, it takes a village to raise a child, it takes really a whole group of people to be able to support someone with BPD and also being mindful so that someone will not have the entire responsibility. So it's sort of a shared responsibility and in my care I was very fortunate to have the team members speak to each other so I didn't have to pass notes, I didn't have to send emails. It was purely they were able to liaise with each other, they had my case notes and yeah, it was a very strong collective approach in terms of my care and my support and I found this highly beneficial. Thank you.

Prof Steve Trumble (00:15:22):

That's great Chloe. Thanks. And it's just so good to hear you say about the timeliness of things being done, that there's real talent in the clinician and knowing when's the moment of opportunity, the tic

moment to actually do something and also the importance of the team communicating so that you're not always running over old territory, but you know that your story has been heard and absorbed by the team in that way. That's great. So thanks so much. We'll move straight to Zonia now, our occupational therapist and hear your presentation. Thanks Zonia.

Zonia Weideman (00:15:57):

Alright, thank you very much Steve. So planning your treatment sets a tone for how therapy will continue and how therapy will end. So the first step is to establish regular therapy sessions. A structured approach might be really difficult for Leah if we think of the case study. And so making other short times available throughout the week with a plan for which she's in distress will really assist Leah to work more effectively with her therapist initially collaborating on identifying clear guidelines around therapeutic interaction just like Chloe mentioned and having them written down really assist in reducing ambiguity later on and is very helpful for both parties. The next thing I generally discuss in therapy is the use of a diary card to record incidents, emotional states, and the use of skills. This is set as an expectation early on as it assist with reflection and provides opportunities for validating a valid therefore reinforcing skills that the person might use.

(00:16:57):

Next slide, please. Fear of abandonment and the fear of rejection in my experiences prevalent in a large proportion of people with a borderline personality disorder. Generally these symptoms do not become overly apparent in the first couple of sessions, but more evident as you attempt to build your therapeutic relationship. During the first couple of sessions, I generally focus on exploring self-defeating behaviours from an occupational perspective. Some of Leah's self-defeating behaviours include overworking to compensate for her fear of possible rejection and engaging in conversations with trolls online as she will eventually receive some negative feedback. I focus on exploring how much time is spent on these self-defeating behaviours and what planning is involved, is there any patterns and where does the environment support these behaviours? What is the emotional functionality of the self-feeding behaviours and how does it form part of Leah's identity? This information is then initially addressed in individual therapy and when Leah's ready, she's encouraged to attend group therapy sessions as it provides that opportunity for peer support that Chloe just mentioned that she valued as well. Next slide please.

(00:18:18):

Functional symptomology of someone with a fear of abandonment and or a fear of rejection in my experience is predominantly demonstrated in two ways. During therapy, the person will either attempt to please the therapist like Leah as they want to avoid criticism from the therapist. And possible rejection or a therapeutic relationship is hard to establish as they fear that the therapist might reject them and they tend to avoid the feeling of failure or abandonment. I've successfully implemented strategies for both of these groups. For the first group, we utilised targeted exposure in therapy. Their initial task is to not do an agreed upon task. For example, one day, maybe skip a diary entry or maybe even miss a session when there's a really good reason for it. Normalising imperfection and the therapist's self-disclosure and some appropriate self-disclosure really around when therapists had to miss meetings when we were sick and how we actually made up to address the situation afterwards really goes so far away. For the second group, I found that rather than spending therapy session talking and attempting to build a therapeutic relationship that doing works better activities that the person with VPD finds interesting and value. For example, I've been shopping for food on a budget. I've gone for nature walks. I've gone through, oh actually I've gone to

numerous coffees. This seems to really help to build a bridge between the person living with BPD and the therapist. Next slide please.

(00:20:01):

Ending therapy is hard for people with a fear of abandonment and maybe perceived as a rejection. So I tend to not end therapy or at the very least I don't use the word ending or termination or concluding. I just validate how well people are doing and say that we need to now test how they would go without regular therapy. I then reduced therapy session in collaboration with the person with personality disorder and I asked them to schedule a therapy session when they need it. This last step is really hard for people and the planning that you did in the beginning of therapy around safety is looked at again in detail before you start this process. Next slide, please Normalising that relationships are tough and that the fear of abandonment and rejection will further complicate. Relationship with carers and families is a good place to convince interactions with Leah and her family. In my experience, it is better to not linger too much on why Leah have an anxious attachment style in sessions with her family, but rather where to from here. So incorporating family and carers into Leah's treatment plan can enhance her engagement, progress and overall wellbeing. This includes education and training of Leah and her family, discussing daily routine planning and the importance of a balanced lifestyle strategies to enhance communication and collaboration and doing something fun together always seems to work well.

(00:21:36):

I always intend to incorporate carers and families throughout the treatment as much as I can. I hope that I noted some new ideas or just validated what effective that really looks like for people with a fear of abandonment and a rejection. Thank you Steve.

Prof Steve Trumble (00:21:53):

Thanks very much indeed. Zonia, I can see that people found a lot in your presentation, so that's great. It's a shame we have to compress everything into these few minutes, but we can explore your themes more fully in the discussion that's coming up. I'm particularly interested in going for a walk with your clients. That sounds like a mutually beneficial thing to do. And now the third presentation from Sathya. Thank you very much.

Assoc Prof Sathya Rao (00:22:20):

Thank you Steve. Thank you Zonia for that very nice presentation. And Chloe, I really want to thank you for your generosity in sharing your information. I put the slide to demonstrate that the feelings of rejection, loneliness, hypersensitivity in inter relationships and fear of abandonment are all quite interrelated. They all tend to overlap on each other and sometimes when people experience many of those feelings together, that can be extremely painful psychologically. And that is something which our case veneer shows and one can think in terms of giving up life. So I just want to caution all of us that these symptoms should not be taken lightly. These are extremely painful thoughts and emotions. Next slide please. And interpersonal hypersensitivity, emotion dysregulation and rejection sensitivity. They all can lead to fear of abandonment and fear of abandonment can lead to all of them. Just the interrelationships I wanted to exemplify and the loneliness of Thank you. Next slide please, Steve.

(00:23:50):

So what are the possible causes of fear of abandonment and rejection? Sensitivity? There are biological factors, psychological factors and social factors of the biological factors. One can actually

inherit a kind of brain, the emotional system that can predispose somebody to develop a fear of abandonment emotional dynamics. Also know there are some studies to early studies trying to hypothesise that fear of abandonment can sometimes be hardwired in people because if they had very early experiences during their childhood, for example, in our case vignette, Leah's mother had postnatal depression. Leah's mother was a migrant, she was unable to provide adequate time and attention for her daughter. So those sort of very early experiences sometimes can get hardwired in the brain. Also, sometimes these experiences can take an addictive quality, one can get used to it so much. Of course the psychological factors are some of the most important ones, which is the attachment difficulties, the early childhood experiences as I mentioned. And if one is abundant as a child, one experiences the feelings of ab abandonment as a child that can again predispose a person to fear of abandonment in adulthood. Of course the childhood trauma factors, feelings of identity, lessness and fear of aloneness, they all can lead to fear of abandonment. Thank you. Next slide please.

(00:25:28):

These are some of the examples of triggers for fear of abandonment. Chloe very nicely articulated and gave the example of how even a full stop at the end of the text message or a door being closed can actually trigger fear of abandonment. These are other things they discharge from the hospitals, commonly triggers fear of abandonment, termination of therapy or end of therapy as other panellists Zonia highlighted, a therapist going on leave can trigger, a therapist cancelling appointments if they're in a weekly therapeutic schedule or when receiving negative feedback at workplace can also trigger fear of abandonment. Sometimes the fear, fear of rejection can be real or perceived rejection. It doesn't have to be, even if it's perceived, that can lead to significant fear of abandonment. Thank you. Next slide please. So some of the ways people with the experience of fear of abandonment can manifest their symptoms is feeling lonely or fear of being alone and emotions getting disregulated, feeling angry or sometimes family violence situations a partner might stay in the relationship despite that being dysfunctional because of the fear of abandonment.

(00:26:54):

Of course it can trigger impulsivity, self-injury and suicidal behaviours and also sometimes idealisation devaluation responses. And sometimes people can feel a bit too attached what is sometimes referred to as clinging. That again is the manifestation of fear of betterment and it can also, it's extreme can lead to dissociations and micros. Psychotic episodes. Next slide please. So what do we do? How can we help people with experience of fear of abandonment? Zonia and Chloe have already highlighted some of the ways we can approach education is the key. I think Chloe, you highlighted that very well. Education regarding fear of abandonment and the person with experience need to know what it is that they're experiencing and become more and more aware of it. Once they become aware of it, we can teach them skills to change it and modify it. And Zonia spoke about how modelling can help.

(00:27:57):

You don't need to be a perfect therapist. Sometimes doing appropriate self-disclosure can actually be very helpful for a person who's experiencing this phenomena and psychological therapies. All the evidence-based ones such as diet, behaviour therapy, mentalization based treatments are all very effective. And a Swiss group have actually developed a specific therapy called the abandonment therapy and they published a paper around that And see mindfulness strategies again can be quite helpful. Rarely medicines such as specific serotonin reuptake inhibitors, that's the example is Celine or cetra kind of medications can be helpful if someone is experiencing severe, severe rejection sensitivity in some cases. Of course there's not much of evidence towards that. Next slide please. I'm

not going to go through the slide. There's just a slide I put to give a few more examples to add to what Chloe highlighted some of the descriptions people provide when they're experiencing fear of abandonment, like saying that you are not there for me or no one likes me anymore, I know I'll be alone eventually. These are some of the thoughts triggered by fear of good. Thank you.

Prof Steve Trumble (00:29:20):

Thank you so much Sathya, and thank you all for being so concise. We've got plenty of time now for conversation, a good 40 minutes or so. So this will be fantastic. But I'm going to start by going back to Chloe. Chloe, you mentioned when you were presenting and judging by what people have been saying in the chat room, you really hit the spot with what people were hoping to hear. But you mentioned the range of people who surround you and I guess that's professional and personal people around you. Can you tell us a bit more about that sort of cloud of support around you? Who's in there?

Chloe (00:29:58):

For me, I did make a choice that I didn't want my family to be involved in my care. I know that with a lot of people with BPD, they do have people, family to support them. So for me, because I lived in a different state to my family, I did end up having a lot of professional supports and really they worked together seamlessly so that I felt I was supported in every way. So for example, even when I did choose to be discharged from case management, it was a very supported transition where there was a lot of interaction with my gp. So that even just say with any medication or anything, the same sort of supports were in place. So to this day, I've never seen a script. I've never had to deal with any medication. It goes straight to the pharmacy. The pharmacy delivers it to my house.

(00:31:04):

I've never had to deal with any of that. And that was just support that was ongoing from case management to my gp who was then willing to follow through with that. And apart from that, some other creative supports as well. So I did actually attend DBT art therapy with a registered art therapist and that was really helpful as well. So despite having two psychologists who worked on different things, I had a key clinician, psychosocial worker who then was able to link me in with community supports in terms of exercise groups and things like that. And it was really, really helpful in my care. And a lot of this was supported and done through case management where they were able to liaise with specialists and also having the referrals to park services. So prevention and recovery services. That was really, really helpful because I know from my own lived experience, hospitals were not the best place, they weren't really conducive for my recovery. I'm not saying that's for everyone, but for me. So whereas going into a recovery centre was far more beneficial where you could work on recovery goals.

(00:32:31):

There was a lot of empowerment, it was voluntary, so if you didn't want to be there, you could walk out any day. So yeah, just having those supports in place. And even with the recovery centres, there were a lot of timed and supported referrals there where just say I had a difficult anniversary coming up or a difficult time, my case manager would then put in the referral for a prevention and recovery centre stay and look sometimes the shortest stay I've had was two weeks, but the longest did end up being about six weeks. And yeah, I think it was really, really important in terms of my recovery. Thank you Steve.

Prof Steve Trumble (00:33:18):

Thanks for that response, Chloe. It was really, really helpful. I'm just wondering whether Zonia or Sathya wanted to comment on what Chloe's said,

Zonia Weideman (00:33:32):

My experience that exactly the same. If we form a really good multidisciplinary team around the person of the person being in the centre and kind of directing us in terms of what is their preferences that works really well towards helping them recover, it's really providing that kind right treatment at the right time and from the right person as well because our skillset sets are so different. So I say we'll have a different skillset that my skillset and it's leveraging of those as much as possible.

Prof Steve Trumble (00:34:02):

Right. Thanks so much. Sathya, I'm not sure you look like you were going to say.

Assoc Prof Sathya Rao (00:34:07):

I just want to echo what Zonia said. I think working together in a multidisciplinary team is very vital, especially because we all are going to take leave. We all might change jobs and if there is a group of us working together, at least one or two people can hold the therapeutic relationship in the long term. So otherwise, if everybody leaves, we are again creating a abandonment for the client.

Prof Steve Trumble (00:34:33):

Excellent. Now I realise I didn't give an instruction about asking how to ask questions. People have figured it out from what was in the bottom of the screen anyway, and a number of questions have already come through the question portal, but if you did want to ask a question, the best way to do it is to hover over the lower part of the screen. Again, you'll see the three little dots over there in the far right hand corner and in click on ask a question and then it comes through onto the proper portal. But I'm going to pick up a question out of the chat box because it's quite interesting, lots of interesting questions in the chat box. This is from Therese Ballard who's asked, could the presenters speak to a phrase that therapists sometimes hear, I can't or I won't be able to take care of myself in that situation. And also, which I guess could be called learned helplessness, maybe not, but also about identity lessness and how to strengthen people's sense of self. So I don't know, satir, are you best to start off with that one? Are you happy to say a few things about that question from Therese?

Assoc Prof Sathya Rao (00:35:43):

Yep. First of all, it's a very common phrase that I hear that I can't, won't be able to take care of myself. I think the first response I would suggest ask clinicians to make is that validated because that's the experience people with borderline personality disorder have. And can you imagine how difficult that is and how painful it is going to be for the person to actually feel that they can't look after themselves? So first is to validate and understand, unpack that statement a lot more as to what do you mean by that? What are the things you can't look after yourself and is that a feeling you feel at times or is it there all the time? So going through all of that and then gradually trying to work with them to make them realise that they have been looking after themselves until now, maybe it has

been very challenging with a great deal of difficulty and trying to show their strengths and working with that on a regular basis over and over and over a period of time.

(00:36:58):

So that's one of the simple approaches to start with that and that learned helplessness is a real feeling, the experience and also trying to find out when did they start feeling like this? Trying to look at the antis and the origins of those thoughts and feelings. The second part is identity. This is a phrase that was used by one of the researchers in the field, and what it talks about is again, the emotion or the feeling or the thought that people with bline perside disorder have that they don't know who they are and they often, even if they know they're not comfortable with who they are, and they tend to look at others' behaviours and thoughts and feelings and personalities and tend to copy that and mimic that at times. So again, very similar principles, but trying to validate who they actually are. Even if they say that, look, I don't know who I am, but that's the person you are then and starting with wherever they are and then trying to work through.

Prof Steve Trumble (00:38:10):

Right.

Assoc Prof Sathya Rao (00:38:10):

Thank you.

Prof Steve Trumble (00:38:11):

What are your thoughts, Chloe?

Chloe (00:38:14):

From a lived experience point of view? I do echo a lot of what safety has mentioned in terms of the validation, just to know that that person's hearing and what worked for me with case management and with my psychologist is that they knew me so well that they knew exactly when to pull the card and really challenge me. So sometimes they'd say, okay, you can't do it. What's the worst that can happen? So I'd sometimes be taken aback, you're supposed to understand me, and now you're asking me what's the worst that can happen? So it's just being able to learn to reframe what I was saying. And yeah, just having that modelling from my therapist. So you are saying that you can't look after yourself, so as Sat mentioned in the past, so you've been able to do this, so now let's reframe this. So you don't think you can look after yourself in this circumstance, but you are able to look after yourself. So being able to model that language and repeating it so that we can then be able to use some of that language and really start to do a lot of self-talk and start thinking, oh, okay, maybe I can. So yeah, just being able to be supported that way. But yeah, just being able for clinicians to know the person well enough to know exactly what the need is at that time and when. Thank you.

Prof Steve Trumble (00:39:48):

Thanks so much, Chloe. Zonia, what's your take on this?

Zonia Weideman (00:39:52):

I think mine is very similar to Sathya and Chloe. I've heard it a lot. I feel empty. I don't feel like I've good identity. I think part of our role as therapist too is when somebody is sitting in therapy, I remind them that you already year to today, so you've already made one choice, this one choice

forms part of your identity. Our identities is just a lot of choices. It's what our values are, it is what our interests are. And from our occupational therapist perspective, helping people to explore that. So what is the doing that you like to do? What is the things that you like to do with family and friends or on your own? What is your values? And using things like values, cards and all those kind of things really help the person to get to know themselves, but also to form that therapeutic relationship with me as a therapist, and this is where I share a lot of things as well, is that your identity can change.

(00:40:49):

I might fried eggs today, tomorrow, I like scrambled eggs, right? That's part of my identity and that's how I develop. So I think it is taking it one day at a time and validating what people have achieved. But like Chloe also said, challenging of people are bringing up these kind of thoughts of emptiness and saying that, all right, well what does it actually mean that you feel empty? Is it loneliness? Is that something we are going to work with? Is it maybe the connection that you don't feel with other people that we need to work with? And really exploring those kind of themes.

Prof Steve Trumble (00:41:25):

Well, I think we've learned a lot from that conversation. Any final comment from you Sathya, or we'll move to another question,

Assoc Prof Sathya Rao (00:41:34):

Just want to unpack a little bit more of what Chloe and Zonia said. It is important to gently challenge them and make them realise that they have been able to look after themselves, et cetera. Word of caution, because first, validate, validate, validate, and validate. Because if we quickly move on to challenging, that can backfire very badly. Then you're saying you're calling the person bluff, you're actually not understanding the feeling of the person. So just being very careful and finding the right time to start challenging. And that is after plenty of validation when you have a good relationship with a person. The next question you asked Steve is about the real loss. Whether that can actually trigger fear of abandonment. Absolutely, yes. I'm sure all of us have experienced that in our lives. However, what seems to happen with people with borderline personality disorder is that it seems to have happened very earlier on in their life. Usually within the first five to 10 years that tends to get live a real imprint on the developing brain, which can set the stage later on for lots and lots of triggers. So a single, single loss can certainly trigger, but usually it is multiple losses, childhood experiences that leads to fear of abandonment in the adult in a person with BPD.

Prof Steve Trumble (00:43:18):

So thank you for exploring that with us. I think you've actually dealt with that question exceptionally well. But I wanted to move to one now that's come from Jennifer Manson who was asked, and I'll put it in the chat there. Does the fear of abandonment sometimes result as a real loss of someone important? I guess that goes to the case study where Paul, what's his name, Damien has gone, is this, what's your approach when there has actually been a genuine abandonment? Is there something different? And I'm including you in this, Chloe, because if you work with younger people, particularly who must experience this, but who would like to start us off with a bit of a discussion about what happens when there actually has been a genuine abandonment in the person's life and what approach you take?

Zonia Weideman (00:44:12):

I'm happy to start the conversation. So I feel our job as therapists is to help our consumers, clients, patients really experience the emotions when they're ready. And this is really tough. This is tough for us as anybody. It's tough, right to experience that and I think validating that. But we also need to understand that we need to grieve and we need to actually experience those emotions in a functional way. So sitting with that discomfort sometimes is really, really tough. So working with the person, living with a borderline personality disorder works well. I think if we actually go, that is fine to experience those emotions. There's no good and no bad emotions. We are humans and we experience all those emotions that goes with loss and with grief and that it is hard and there's no shame of one day choosing to be miserable or two days choosing to be miserable. That is perfectly fine. And all of us go through that and then it is standing up on the other side and continuing. And I think that's the bit that we can help people with is carrying them and hope, holding the hope for them when they don't have it themselves.

Prof Steve Trumble (00:45:30):

Thanks. Any other comments about that?

Assoc Prof Sathya Rao (00:45:34):

I think that was beautifully explained by Zonia. Thank you. If there is a real loss, people are going to feel grief and grief and loss experiences as Zonia very nicely illustrated. And that is a normal emotion. We want to help the person grieve adequately. And if that gets prolonged for a long period of time or if that triggers excessive emotions, which is experienced as being very painful for the person. And that is if it takes on other added qualities or if the person starts thinking and feeling that no one will ever is going to be with me, everybody is going to leave me, et cetera, et cetera. Can you see the added on qualities? If that happens, then you would want to, or if that takes the proportion of then you would want to work with that, but that's a very skillful work. You want to validate the grief and you'd want to gently also work with the add-ons. And as Zonia said, you need to give a little bit of time for the normal grief to process and the other complicated grief which comes on later on needs to be worked with.

Prof Steve Trumble (00:46:57):

Right. Alright, well there's actually, I've just been a bit keeping an eye on the chat box. There's quite a lot going on there with people talking about what about comorbidities or other diagnoses and particularly A DHD people have also mentioned PTSD and they're wondering particularly in the way the case study is presented, whether it could be that ADHD would need to be considered for, I'm just wondering what people think about teasing apart the diagnosis. What's people's strategy for there? Because there's been a lot of questions about that. Looks like you're in the hot seat, Sathya

Assoc Prof Sathya Rao (00:47:41):

Happy to start, Steve. Look, post-traumatic stress disorder, PTSD is a very common co-occurrence with borderline disorder. Nearly 50 to 60% of the people will have PTSD. And if you're looking at complex PTSD, again, half of the people with borderline post disorder will have complex P ts D. Now our client now, whether she has A-P-T-S-D or not, there's some information to support that, but there's not a whole lot of information, so to say it is PTSD. They need to have first of all, recurrence phenomena, flashbacks, nightmares, avoidance behaviours, hypervigilance, et cetera, et cetera. They're all set up. Set criteria needs to be there and the person needs to experience the trauma, either childhood sexual abuse or adult traumas where the person's life is at a threat. So we don't

have a whole lot of information to make a diagnosis of PTSD, but it's a worthwhile differential diagnosis to consider and explore in the future.

(00:48:49):

ADHD again is not uncommon in people with Borderline Personality Disorder, about 20 to 30% of the people will have co-occurring ADHD. And whether Leah also has ADHD, again, I would consider it as a differential diagnosis. Right now there's not a whole lot of information. Commonly if there is adult A DHD, they would've had childhood A DHD, and there would've been signs and symptoms. Again, we don't have information towards that, but one needs to keep an eye to explore to the future if she does have a DHD treated with stimulants if required or with psychological strategies as appropriate. One more thing to remember is that childhood A DHD is a very significant risk factor for adult disorder.

Prof Steve Trumble (00:49:39):

Thank you. Zonia, did you want to add to that further?

Zonia Weideman (00:49:45):

I'll add maybe just one thing is that whatever the diagnosis is, and OTs generally don't work on a diagnosis, we work on symptomology. So really we would look at what is the functional impairment that Leah is demonstrating to us and we we'll work within that. And I think the five functions of treatment, from my perspective is to really improve Leah's motivation, to work towards her recovery, to enhance her capabilities, to practise her skills. That might be if she's A-D-H-D-P, D-S-D-P-D, to really make sure that her environment and her family supports her and that she works effectively towards the goals that she has identified. So from my perspective, I work on functioning not as much on diagnosis.

Prof Steve Trumble (00:50:36):

That makes a lot of sense. And I think that's where the complimentary team really comes into its own by taking those different approaches and just noticing somebody in the group talking about the sensitivity of people with A DHD, and that might be something that the occupational therapist could help with, I guess to try to modify the environment so that it's not quite so overwhelming for people. Okay. I'm absolutely fascinated by this comment that has come from, who am I going to dob in for making? It's a great comment. It's Amanda. Amanda Clayton has made the comment that after reading the case notes, the first thing that occurred to her was the need to gently encourage to acknowledge what she does well and develop an acknowledging and compassionate inner adult. What does our panel think? So I guess maybe it's back to you, Zonia, and then if Chloe or Sathya wanted to jump in,

Zonia Weideman (00:51:40):

I would definitely start with validating that Leah has done extremely well with different areas of her life. She comes from a cultural background where it is tough, and I think she's managed that and navigated that complex situation really well. She's doing well at work. So there's heaps of things that we can validate, and that's what Sathya said from the beginning. We validate, validate, validate before we start challenging and we make sure that those validations help us enhance our therapeutic relationship. I'm not sure about the compassionate inner adult, I'm not sure about that language, but definitely from my perspective, offering her a lot of compassion of what she's gone through, and I think that she's doing really well in certain areas.

Prof Steve Trumble (00:52:29):

Any other comment from the panel about that?

Zonia Weideman (00:52:33):

Chloe, do you want to say anything before I

Chloe (00:52:37):

Yes, I do. So based on this comment, I do actually agree with having that person centred approach, being able to acknowledge the strengths of that person. Even for myself, because after 10 years or something for myself where I really, really struggled to see the world through anything but an so-called negative lens or a very dark lens, it was very hard to see the good in myself. So there was a lot of self blame that I'm faulty. I remember the comment that I often made that there's innately something wrong with me because personality disorder, there's something wrong with my personality. So even from the very foundation, just for someone to support and acknowledge the strengths of the person, it was really, really helpful. It didn't mean I acknowledged it straight away, but the more it was repeated and repeated and repeated, then I'd thought, oh, maybe there is something good about me. Because for me, it took many, many years before I was able to get support and really take off those negative lenses to be able to see things for what they were worth. Thank you.

Prof Steve Trumble (00:53:53):

Thank you Chloe. Sathya, are you tensing yourself to speak?

Assoc Prof Sathya Rao (00:54:01):

I just wanted to again echo what Zonia said, that when someone has self-critical thoughts and self-loathing feelings, the common tendency of clinicians is to disagree and challenge and say, no, no, no, you're really good. You're really good at this. That is experienced as invalidation by the person because they don't actually feel it. And you are actually trying to say that what they're experiencing is not right. So first as to, as Zonia said, gently validate but not validate too much. You might say something like, given what you're going through, I can sort of understand why you have these feelings, why you would blame yourself. Trying to link it up with the development trajectory so that it takes away the blame for even feelings, having self-loathing thoughts, they can self loath. So trying to be very gentle and try and validate that first and then trying to ask very gradually working through, because sometimes we can get a bit too enthusiastic and look at self-compassion therapy that can again be very, very hard for people with borderline post disorder with this thoughts to undergo. So very gradual, showing us showing compassion and checking in with them. Is that hard for you if I show compassion and then getting them to gradually work with their own self-compassion thoughts. And given the kind of harsh parenting, potentially she's dead, of course may have been culturally appropriate, but she's likely to have interjected those sort of emotions and feeling that also gives a clue that probably she has PTSD.

Prof Steve Trumble (00:55:54):

Thanks. So I'm going to pick up on your discussion of compassion there and take a question from Tyson, Rosa Oli. And there's actually been a few along these lines as well, and Tyson's asked, how can you help patients build resilience in a stronger sense of self-worth to counteract feelings of

abandonment? What do people's thoughts about that? Is that something that you would consider Zonia or Chloe?

Chloe (00:56:25):

Yes, I can talk to speak to this. So what I've noticed in mental health, a lot of people are looking for quick results. For me, it took years of therapy, very targeted therapy to be able to change those unhelpful patterns of thinking. For me, myself, I often think it's taken me 20 something years to build up this way of thinking. You cannot expect someone to change overnight. It takes a lot of time, a lot of work to be able to counteract those feelings and then to be able to really see the face value of what things are. So yeah, I think a lot of patience. It's not something that will happen immediately. It takes a lot of time, a lot of emphasis, a lot of repetition to be able to help the person be able to gradually change their patterns of thinking to a way that is more helpful and helps them function in life. Thank you.

Prof Steve Trumble (00:57:36):

Thank you. We've got time for a couple more questions. And there was one that's come up a number of times, which is about this condition at extremes of not extremes of life, but later in life and early in life. I know Chloe, you've worked with children. I'm just wondering with the others, there's been a question from Phillip who has asked, would you please be able to comment on the prevalence of mature age people experiencing the onset of BPD symptoms and how this can be triggered and can this be triggered by real life events such as divorce or death of a partner or things like that? Is that something that people are familiar with as some therapists? You're nodding, let's hear what you've got to say. What are your thoughts about that? About what happens later in life? Any different approaches

Assoc Prof Sathya Rao (00:58:36):

You are asking Zonia or Chloe?

Prof Steve Trumble (00:58:39):

Well I'll ask you Sath, I guess you and I represent the older generation. What are your thoughts about what happens when somebody has an issue in their life that might trigger this? I think Zonia's frozen on our screens, so it looks like you're in the hot seat.

Assoc Prof Sathya Rao (00:59:00):

This is something which just come up in the last 10 years for us, we find at spectrum where I work, a third of all the people who access the services tend to be people who are in the Middle Ages. They've often not had any diagnosis of BPD so far, but they had the childhood risk factors and some situations, trauma factors, but throughout their life they've been fine without any symptoms. But when our hypothesis that they did not develop the symptoms because either a long-term relationship or a stable job has sort of been a protective factor and they would've still experienced psychological distress, probably they did not have symptoms to make a diagnosis. However, if there is a relationship loss or a loss of a job or sometimes in older age when they go to nursing home or when they retire, these are all the factors which can actually trigger and people can come up with borderline disorder for the first time. We have worked with someone who was 78 years old coming at borderline disorder for the first time. So it's now well known. We don't know the prevalence yet though. There's no good studies to show that. But we did a survey of old age mental health clinicians

in Victoria and they said that 10% of all the patients in older age tended to have borderline personality disorder.

Prof Steve Trumble (01:00:35):

Okay, well thank you. I think that's really answered that question. We're getting to the time now where we need to start moving into final comments. Please stay with us, everybody in the audience. There is a question though, which has come up for a number of people, both in the chat group and also in the questions. What does recovery look like? And Zonia, I might go to you. First of all, what does recovery for somebody look like for somebody with BPD?

Zonia Weideman (01:01:04):

I think from my perspective, recovery is somebody functioning well within their community, within their friend group, within their family group, and it's them meeting the goals that they want to achieve. We have people who their recovery look like not self-harming for a period and being able to get tattoos on that self-harming area, and that was their recovery. Then we've had people who became peer workers, had people who became nurses within our mental health unit. So I think in the end of the day, recovery looks different for everyone, and I think that's an individualised journey, but from my perspective, it is when people can function at the level that they want to function and achieve the goals that they want to achieve. And I'm not saying that recovery is ever going to be without any bumps in the road. We all have bumps in the road, and I think that's really important to note. And we talk about that quite openly, that as a therapist, I have to do daily mindfulness, daily self-care, make sure I live a balanced life, go to the gym, I need to do things to make sure that I stay well. And so that's the same for people with BPD.

Prof Steve Trumble (01:02:22):

Right, thanks. And Chloe, there's a comment in the chat saying that you sound like a powerful woman. Well done. You without world currently being very dependent on a powerful woman, this is a very timely question to ask you, what does recovery look like?

Chloe (01:02:40):

From my own experiences, I have never said to anybody, I have recovered from BBDI myself, see recovery as a lifelong process. However, I do see that I've recovered to the point where it doesn't affect my daily functioning. And that's the point where I say, yes, I've still got plenty of things to work from work on, and I don't think I have recovered, but I can now function and be able to have my goals and what I'd like to achieve fulfilled because of the recovery that I have experienced. So yeah, I'm not sure if I would ever say that I have recovered and I do to this day see recovery as a lifelong process.

Prof Steve Trumble (01:03:33):

Okay. Yeah, people have said it's not linear in the chat and you think you've made that very clear to us. It's just not that simple, is it? But actually, Sathya, from the psychiatry perspective, what's your view of recovery? What does that mean for somebody with BPD?

Assoc Prof Sathya Rao (01:03:49):

See, unfortunately, recovery is a phrase taken for the medical model. It doesn't really lend itself very well for people with border personal disorder. So we want to individualise, as Z said, define with the

client what recovery might mean for the person. So that's what we want to work with. There is some research which has been done from both New South Wales as well as from spectrum. We have actually worked with the clients and to articulate what recovery might mean, word of caution. We don't want to change people's personality. People with boing person disorder have vibrant personalities. Bright personalities, and we don't want to change that. We don't want to work. We don't want to retain that and foster that. What is not working for them is what we want to change, help them change.

Prof Steve Trumble (01:04:48):

Thanks. S and I always feel a sense of grief when we get to this part of the evening, and there are so many great questions still to be asked, and we will share those questions with the panellists so they know exactly what people have been interested in. A lot of it's been covered as the presentations and the conversations gone on, but there's still plenty to talk about. Please stay with us, everybody. We've got 10 minutes to go and in these final 10 minutes, we'll hear from each of our panellists just saying a few final words about the topic and what they've heard from people. Again, Chloe, I can't help but look at the chat box and see Isabelle saying You're an inspiration and a representation of hope. So with that lead in, what are your final thoughts on the topic

Chloe (01:05:39):

For people out there? People working with people with borderline personality, sorter with fear of abandonment. There is a lot of unpredictability, but please note that the person is hurting as much as it's hurting people around them consider how much the person themself is hurting, and hence, this is why we see these behaviours. There is so much emotional hurt within them that they can't help but try and take control of what they have around them. And just being really curious about what's happening. So often I do say, be curious before furious. So it's not that reactive approach, it's more about having that proactive approach where we preempt things that are going to happen and we build supports in place so that we don't wait until there is a very heightened moment before we and put things in place. So yeah, just being able to listen to the person and having that patience as well.

(01:06:51):

As I've said before, recovery doesn't happen with BPD overnight. It doesn't get so-called fix with a tablet, it doesn't get fixed with a week therapy. It takes a lot of time to change those patterns of thinking that haven't been working. And yeah, it's a lot of commitment on both sides, but knowing this, the person themself has to be ready. We can't impose therapy on someone with BPD because it is a very active process and if the person's not ready and there's no buy-in it makes it really, really difficult and pretty much you are battling against something that it's not going to happen. So they're really my last words to leave with everybody. That compassion towards somebody who is in a lot of pain, a lot of emotional pain. It's not so much physical pain, but the emotional pain can be close to unbearable for the person in every aspect of life. Thank you Steve.

Prof Steve Trumble (01:07:55):

Thanks, Chloe. That's such important words that I'm going to get cards printed up with. Be curious before Furious because it's actually something we try and teach gps that if somebody is challenging you as a patient, be curious about what that means and don't get angry, get interested. And it was interesting the last time we had one of these presentations that GP colleagues said to me that they actually like people with borderline personality disorder coming into their surgeries because they're

engaging and it's interesting and you come off autopilot. Anyway, that's my fit. Zonia: Takeover, please. What are your final thoughts about tonight? Well,

Zonia Weideman (01:08:36):

I don't have a slogan so I need to really think quickly now, but from my take home messages is that the relationship is really the key and should be our first focus. Collaboration works best and this is a relationship between equals. We no longer have the therapist sitting on the chair and the patient lying on the couch. It's a relationship between equals we work together. I think one of the most beautiful stories I've heard is from a therapist perspective and a person living with borderline personality perspective is we are two people both rowing in a boat, right? We are both rowing in the same direction. The person with borderline personality disorder is sitting in the front. They are steering, they are providing the direction. So what from a therapist point of view is I'm rowing as hard as that person is rowing, what we sometimes do have is that the person in front is drilling little holes in the boat and that is we need to acknowledge that and we need to get some water out, fill those holes, but keep on rowing.

(01:09:35):

And I think that's the most beautiful thing that I've heard from a therapist perspective. I think the other thing is that self-disclosure, appropriate self-disclosure, like Sathya said is really important and that, like Chloe said, recovery is not an end goal, it's a lifelong journey and I think that's really important. I think the last thing I just might say is from a therapist point of view is supervision is really, really important. Make sure you get robust and frequent supervision well for a couple of reasons, but one reason is really to make sure that you provide the best care that you possibly can for people living with personality disorder. But I think the other one is to make sure that you stay well as well as a therapist because there's not a lot of people out there at the minute that provide, that wants to take on people with borderline personality disorder, which I don't understand because it's my favourite part of my role, but it is something that we do need to think of

Prof Steve Trumble (01:10:32):

That is so important. Z you guys are such a valuable limited resource. There's been conversation in the chat about how hard it is to find therapists and access them. So keeping healthy is really important as well. And remembering that it's not just a little robot, it's a racing eight to have an Olympic strategy, you've got lots of other people in the team who can convey that coxin to their best living. So it's really important to make sure that everybody's pulling together in the same direction. I've milked that analogy as far as it's going and then a little bit more. Satya, what are your final thoughts before we wrap up?

Assoc Prof Sathya Rao (01:11:08):

Thanks Steve. My first take home message is that people with Borderline Personality Disorder do improve and do recover all the time, and we just need to change our nihilistic sort of viewpoint about this. The second take home message I want to convey is that you don't have to be a perfect therapist. You can't be, in fact, it fails if you try to be, you just need to be a good enough therapist. You just need to do a good enough job. If you remember what I said earlier on that no people at Borderline Personality Disorder are most forgiving. In fact, if you're a good enough therapist, because if you try to be heroic and you want to do heroic things, it's not going to work. And also you are going to burn out very quickly. You just need to be yourself and do a good enough job and take care about a few things.

(01:12:09):

And that seems to work. And now the research shows that what is the most juicy bit in all those evidence-based psychological treatments, dialectical behaviour therapy, mentalization-based treatments, so on and so forth. The most important aspect of all of those treatments is what Zonia said. Therapeutic relationship. Therapeutic relationship accounts for 50% of the outcome. So if you're a good enough therapist and manage your therapeutic relationship, you can go a long, long way in helping a person with Borderline personality disorder. You don't have to have extensive training in all the specialist therapists to work with people with borderline PERS disorder. I would highly encourage you to work and as I said, my professional satisfaction has been great working with people with borderline personality disorder. Thank you.

Prof Steve Trumble (01:13:04):

Fantastic. Stacy, thank you. I think you've reminded us to be who we are and be curious and not spurious maybe. Maybe that's another set of cards I'll need to get printed up. I'm getting T-shirts made. I thought that was just brilliant. So thank you all so much and I must say I've not seen such an active chat with people being so grateful to what's been shared tonight. Obviously the very personal viewpoint from Chloe and the highly skilled viewpoints from Sathya and Zonia. So thank you. That's been great. We do have a few things finished up with, and people please don't leave before you've done the feedback survey. You can see that again, that lovely teal coloured button down the bottom there, complete feedback survey. So please do that before you go. So a few other things just to talk about before we finish up. And the first of those is to remind you, there's another webinar coming up on the 9th of September, which is how to apply the principles of mentalization-based therapy in your practise with people who have borderline personality disorders.

(01:14:13):

So that'll be interesting to find out more about mentalization-based therapy. There's a podcast which are a great way of making a trip pass. This is about journalism and mental health to conversation about that. So please look for MHPN presents in your preferred podcast app just there next to this. The rest is history in Hamish and Andy. It'll be there. You'll find it. Top rating. MHPN also supports more than 300 networks where mental health practitioners meet both online and in person to engage in free interdisciplinary networking. And again, that network is so important. Vital peer support, again, vital and also ccpd like tonight and you will get your certificates. If you're interested in finding out more, then please go to mh pn.org au. Now don't forget, coming up 1st of October is BPD Awareness Week and that's focused on living life. Well, for further information on events in your state, please visit the BPD awareness website, which is included in the webinar, supporting resources.

(01:15:24):

That button down the bottom of the screen there. So thank you for participating in tonight's webinar. Thank you to our three fabulous panellists. Please complete the survey. Either click on that QR code you can see on the screen there, and we all love those or click the button for completing feedback. Survey can't be easy, but please do. It's really important to us. The statements of attendance for your CPD will be on the portal in two weeks and the recording, which is entire and also can be accessed with transcript, will be available in one week. So it's eight 30. Time to close before I close, eight 30 on the east coast. I should say. Before I close, I would like to acknowledge the lived experience of people and carers who have lived with mental illness in the past and those who continue to live with mental illness in the present. Thank you to everyone on the screen and also at their keyboards for participating this evening. And I wish you all the best. Thank you.