**The Peregrine Centre Rural Mental Health Podcast**

Episode 3. Working with People with a Diagnosis of Borderline Personality Disorder

**Speaker Key:**

CM Caitlin Miller

NB Nicholas Bendit

ND Nicholas Day

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Intro Hello. I'm Dr Rebecca Sng, director of The Peregrine Centre. As we begin this episode of The Peregrine Rural Mental Health podcast, please join me in stopping to consider the land beneath your feet, where you might be listening from today. Let's take a moment together to acknowledge the traditional owners of that land. We pay our deepest respects to the elders of the past, those of the present, and the emerging elders of tomorrow. The Peregrine Rural Mental Health podcast is brought to you as part of our rural mental health partnership with New South Wales Health.

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CM Hello, and welcome to this episode of the Peregrine Rural Mental Health Podcast. My name is Caitlin Miller. I am a research associate and clinical psychologist working for the Rural Mental Health partnership at the Peregrine Centre. Today we're talking about Borderline Personality Disorder, which is commonly referred to as BPD.

I am lucky to be joined by two guests who have a wealth of knowledge that they can share with us. The first guest that I would like to introduce is Dr Nick Bendit. Welcome, Nick, and thank you for being here and sharing your time with us today. Could you give us the 25-word version of who you are, your training background and what sort of work you do with mental health?

NB Sure. I'm a psychiatrist, I work in a publicly-funded outpatient clinic where we provide one to two years of targeted psychotherapy to patients with borderline personality disorder. And that's really my main role, although I do have a supervision role across Hunter New England, including a lot of rural sites, where I supervise difficult borderline patients the teams are dealing with, or individuals are dealing with. And I've also been involved in a large randomised control trial, comparing The Conversational Model, a psychodynamic model, with DBT, Dialectical Behaviour Therapy.

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CM Oh, wonderful, thank you. And I am looking forward to picking your brain about a few topics today. Our other guest for today is also called Nick, Dr Nick Day. Thank you for joining us, Nick. Would you be able to give us the spiel of who you are, your training background and what sort of work you do in mental health?

ND Yes. I'm a psychologist, a registered psychologist, and a research fellow with Project Air Strategy, based in the University of Wollongong. So, clinically, I'm trained in dynamic therapy and I practise something called Transference Focused Psychotherapy. It's an evidence-based treatment for Personality Disorder. But in my research world, at Project Air, we're just trying to increase the evidence base and improve services for people accessing treatment who have a diagnosis of Personality Disorder.

CM Thanks, Nick, and looking forward to hearing your opinions as well. So, today we're going to start with some general questions about BPD, to set the context for our listeners.

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And then we might dive into some more specific questions about working with people with BPD, particularly around how generalist mental health practitioners can support this population, and how they can work in an area where there might be limited services available, like regional or rural areas. So, Nick Bendit, would be able to start by just giving me a brief description of what you think the main challenges or symptoms are for someone with a diagnosis of Borderline Personality Disorder?

NB The difficulty for the client, the patient, is that generally, their lives are miserable and chaotic. And they feel hostage to storms of emotions that they don't know what to do with, which not only make them feel dreadful from the inside, but also lead to lots of chaos on the outside. Sometimes it's a quiet chaos, but it's still chaos and still not working and functioning.

Then the second problem is that they engage with our mental health system, and we use all the wrong things to try and help them, so that they end up feeling worse, and they do two things then. They blame themselves and feel like they're failures, and then on top of that, they believe that nothing will work, because I've been diagnosed with anxiety and depression, I've been taking these medications, I've had CBT, and it's not working. So, something wrong with me, and nothing will work, are the biggest problems, I think, in this area.

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CM What a succinct description of something that is really complicated. I like how you said the sort of storms of emotion, I can certainly resonate with that with people that I've seen in the past. Nick Day, what's your perspective on this?

ND Yes, I was thinking about how, just kind of been thinking about what the main challenges are for somebody with a personality disorder, and the shift that's happened in the diagnostic system I think has been really helpful. I get really confused, and I think a lot of people get confused, when we look at symptom lists in trying to find symptom clusters. There's some really important ones, some really core ones, that a lot of people struggle with.

So for BPD, it can be things like feeling empty inside, not knowing what their identity is, self-harm and suicidality. And those are really true, but more recently, it's really been simplified into self and other functioning. I think that really gets to the core of what's going on here, difficulties with identity, difficulties with what

you want out of life, where you're going to go. Difficulties with managing emotions, and other relationships, having fulfilling, mutual, well-connected and deep relationships with other people. So that's really been helpful in understanding the core of the issue for me.

CM For our listeners who might not be aware, in the Diagnostic and Statistical Manual 5, there is an alternate classification for diagnosis of Personality Disorder, which, as Nick says, talks about it in more broader terms of problems, interpersonally, and with yourself. So, say that I'm a mental health practitioner, and I get a referral that says the presenting problem is BPD. What might I be worried about, and what might feel challenging for me, working with this population, Nick Day?

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ND I think the first thing that would probably come to mind is issues of risk. Whether it's, as we were saying, these kind of symptoms of self-harm and suicidality, it can raise anxiety, people are not sure what they're going to do with it or how it's going to manifest in the treatment. So I think that's a clear and present danger sometimes.

CM Absolutely.

ND But I think, beyond that as well, I think there's also these issues of strong emotions and interpersonal difficulties that are kind of core to the disorder as well. And I think people might be nervous about how they're going to manage big emotions, what's that going to look like in the treatment, and this kind of hypersensitivity and feeling I need to walk on eggshells when starting to treat these patients. I think all of that can be high in people's mind when they begin to see someone, it can be pretty challenging to manage.

CM Yes, and it's certainly a lot to think about when you get a referral like that, isn't it? Nick Bendit, do you have anything to add to that?

NB Yes. I think the difficulty for most clinicians is that you have to change your approach from your usual approach as a mental health clinician. So, instead of thinking in terms of diagnosis, medications, all the usual things, social supports, community teams, hospitals, and now the NDIS, all of that is fundamentally useless. And that's a problem, because they're the tools that we use for most of us in mental health.

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So we have to rethink how we're going to do it, and the new tool, the tool that is essential for these clients, is engagement. Engagement is more important than any of those things. And so we have to work on, and I'll talk a bit later, perhaps, on how to engage with them, what is necessary, what's the heart of that. But the other thing, as Nick said, risk is challenging, and here you have to be slow with risk. Rushing to risk plans, putting people in hospital, is generally not that helpful, we have to do it occasionally, but often it's not helpful.

So we have to be slow with risk, and we have to focus much more on understanding the client's important relationships. Who really matters to them, and how is that playing out in their lives? The last thing I would say that's different,

is that I think it's really important if you're going to work with particularly chaotic and challenging and frightening patients, you need supervision. I have been doing this for 25 years, and I have regular supervision. It's too stressful otherwise. It's a really manageable thing to do with good supervision, but without supervision it is a very stressful and lonely, and sometimes frightening, process.

CM Absolutely. And I think that is something that is important for all practitioners, working with all presentations, but particularly working with people with a diagnosis of BPD. It's also interesting, you know, in the question I said, what might I be worried about, and what might make me anxious as a clinician… And it's interesting that one of the things that are most important is the engagement and the rapport-building.

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And I think sometimes our anxiety as clinicians can actually get in the way of that. We know from the literature, that for some people, receiving a diagnosis of BPD can be experienced as really validating and really normalising, and it can make sense of their experience and what's been going on for them. For other people, it can feel really challenging. We've talked about chaos and emotional storms and risk. Nick Bendit, if you had someone who was sitting in front of you and had just received a diagnosis, had just learnt all of this stuff about themselves, was feeling really hopeless, feeling like there was no future for them, like things were never going to get better, what would you say to someone like that?

NB The diagnosis of Borderline Personality Disorder was a kind of death diagnosis, 30 years ago. And so out of that came a lot of stigma, and a lot of services saying, we can't treat them, we won't treat them, they're problems, they're pests, get rid of them, there's nothing we can do. That's really changed. So I would say to them, something like, I understand that nothing has worked for you so far, and you're feeling pretty hopeless. Because when nothing works, no wonder you think nothing will work.

However, I would also say that… For example, in our trial, we found that 82% of our patients in one arm, did not have any suicidal actions after seven months of treatment, after that. And that was sustained for five years. So four out of five patients in the year of treatment, of appropriate treatment, will stop completely having suicidal attempts and significant suicidal ideation, settle right down, and that will be sustained. So there's real hope here, and that's probably the best antidote to hopelessness, is to say, I understand you're hopeless, but there actually is a lot of stuff now, showing that most people who stick with it, will do it pretty well.

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CM Wow. And I know that we have come really far from when BPD became a diagnosis in the 1980s to now, and I think sometimes the stigma that has been sticking around since then has gotten in the way of people's perception. But as you say, we do know that there is hope for a better life and a better quality of life. Nick Day, if you had a client that you were seeing, who was sitting in front of you feeling hopeless about the future, and who'd just received a diagnosis, what would you say to them?

ND I think I would definitely lead with the hope message that Nick's also touched on. Not only is treatment available and helpful, and people recover, there's a wide variety of treatments available, they're very different, they're more skills- or more relational-based, so there's also treatments that could be tailored to the person. There's also research that even shows that people get better without treatment, over time, when they get older, that they just kind of, symptoms decrease and things get more stable.

So in essence, it's a good news story in a lot of ways. But the other thing is that, one, I would be delivering a diagnosis, and also personally make sure that I'd stress that we couch it in terms of Personality Disorder, but we're talking about personality here.

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Like, what they're struggling with, what we were saying before in terms of self and other functioning, this is the central part of being human. All people struggle with emotions sometimes, all people have identity crises, sometimes unsure who they are and where they're going in their life, all people have difficulties in relationships. So they're struggling with things that are deeply human, they're not somehow other or alien, but they struggle more than other people. And that's what we can try to help them with, with a bit of treatment.

CM Such a great response. I can imagine that lots of people would feel quite hopeful and validated after having that experience. You mentioned that there are treatments available that are effective. Could you run me through some of the main treatments that are available?

ND Yes. So there's a whole range of treatments. There's these kind of, if I could broadly categorise them into skills-based or relationship-based, there's ones that… Skills-based treatments are really focused on giving practical skills and coaching, to really tackle the main symptoms of Personality Disorder or BPD specifically. Those can be things like emotion regulation, self-harm, suicidality, managing relationship conflicts and so on.

And then there are also, and they are more relational-based approaches, this is what I practise specifically. And that's also looking at the therapeutic relationship as the mechanism of change in a lot of ways, focusing on the here and now, what's happening between the two of us, and using that as a template to understand relationships on the outside. It's a bit more exploratory, they're very different on paper, you could say, but they're also tackling a lot of the same issues.

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But I also would say, and I think this will come into the fold as we talk about it more, is that we can get a bit stuck in treatment types and treatment labels. There's also generalist approaches. A lot of these treatments require years of training and supervision, and theory and all of that, but there are generalist approaches as well that people can implement, regardless of therapeutic modality, and it can be helpful in a wide variety of settings. So we'll also touch on a bit of that, maybe a bit later.

CM I think it's often referred to in the field as common factors of therapies that might be useful across different modalities. Thanks, Nick. Nick Bendit, do you have anything to add to that, about specific treatments?

NB I might add just one thing, and I must just take a little further what Nick was outlining. Every, and I think this is the common factors thing… There are a bunch of different models that have been shown to be therapeutically effective, and very effective. And they're widely divergent, as Nick says, on paper. But the common factor, which is, how do we talk about your emotional, to the patient, your emotional experience, and how do you and I process that together, is common in all the effective treatments.

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If that is a part of it, it's going to work, in my opinion. And that's certainly common to each of the models that have been shown to be effective.

CM So do you mean by that, helping the client to understand and make sense of their emotional experiences?

NB Yes. Well, yes, exactly. And the first step to that is to help them to… It is to listen, it's to focus much more on emotions than on the details of their life. In psychiatry and psychology and mental health in general, we tend to focus on the details, on the practical things within their lives. But it's actually the emotion experiencing that is the core thing, the clients with Borderline Personality Disorder, that's the thing they and us need to focus on.

And there's a lovely book called Half in Love With Death, by Joel Paris from 2007, which describes the research, but also the practical ways to work with this population. And what he says in that is it's kind of simple. If you are able, at any interaction, if you're able to listen to their emotional experience and respond to that, you will be doing good.

CM I personally really love that book, and I think it has been really formative for me as a clinician, so I'm glad that you mentioned it. And, yes, I think it's such a good message, that it's so easy when people are feeling chaotic and feeling like they're in the midst of emotional storms, to get caught up in the chaos ourselves. And focus on the content, rather than focusing on the emotion.

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While there are a bunch of different treatments that are available and are effective, I think that's a really good core message to take away, that these are the things that are difficult, the emotional experience, and often not understanding the emotional experience that people have, and that is where we can be most effective. So, Nick Bendit, you've just mentioned that there are a bunch of different treatments for BPD. Something that often gets asked to me is, is BPD just complex trauma? Would you be able to talk to me about this idea, that BPD and complex trauma are the same thing, and how treatment might be similar or different?

NB Yes, so that's a good point. I think, fundamentally, BPD is a complex trauma kind of experience, as against simple trauma. What I mean by simple trauma, I mean

one-off traumatic, emotionally traumatic experiences, which are treated with PTSD specific treatments like cognitive processing in cognitive therapy for PTSD, EMDR, imagery rescripting. None of those are really effective for this, because of the complexity in Borderline Personality Disorder.

And where that complexity comes from, is that, added at the bottom line, BPD is caused by caregiver difficulties. It's around the experience of caregiving, from very, very early, and usually the first years of life. And that needs to be worked on, that needs to be addressed. As a consequence of the caregiving difficulties, there's real problems then with emotion regulation and emotion dysregulation. So the antidote needs to be a caregiver antidote. It needs to be a different experience of care, which is why the therapeutic relationship, as Nick Day was saying, is central to every model that's shown to be effective.

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So it's complex in that we have to address that, but we also often have to address PTSD -type symptoms from sexual abuse and violence and domestic violence and so forth. They are important, but without the caregiver response, we won't get anywhere.

CM It's really interesting, I think, in mental health training in Australia, sometimes we are discouraged from providing a caregiving relationship. And I wonder if that sort of reflects the message you were saying at the start, around how all the normal stuff that we do doesn't actually work for these clients. The next question I have is more of a rural- or regional-specific question. Nick Day, I'm going to start with you.

Something that we often hear is that, in regional or rural areas, the reality is that there might not be services to refer someone with a diagnosis of BPD, if they're referred to you. Now, two of our 2022 small project grants are focused on delivering telehealth care to people with BPD or complex mental health concerns, which, if effective, will hopefully improve some access to treatment. But, unfortunately, the reality for many people is that there aren't specialist services to refer to in the area.

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And I think this brings up a tension between, on the one hand, providing care to people, and on the other hand, practising within your scope of competence as a health professional. Do you try to provide something that might be helpful? Or is the responsible thing to do, to refer on? So, I'm going to say a statement that I think gets to the core of this issue, and I'd love to hear your opinion on it. So, the statement is, as a generalist mental health practitioner, so someone who doesn't have specific training in BPD, providing some treatment to someone with BPD is better than no treatment. Discuss.

ND I'm in two minds about it, which is, I guess, why it's a great question. My first response, actually, was that I'm pretty strongly in favour of people being able to make a choice about the kinds of patients that they take on board. And that, when I think about what it means to start seeing somebody with a personality disorder, what are the common reactions that clinicians can fall into, of

overextending themself, of losing track of boundaries and giving more than they perhaps feel comfortable to do.

And so I kind of want to hold the space for clinicians to be able to make a choice about saying yes to agreeing to treat someone when they may not feel comfortable to do it, and the way that that might replicate a really unhelpful dynamic in the treatment. So there's a case, I think, for, to be able to demonstrate boundaries and to demonstrate self-care and -respect in saying no, and not taking on a patient for that reason. But then the other part of me says, well, I think that statement's true, and that you can, even as a so-called generalist clinician, there's a lot that you can offer without specialised training.

In fact, that's the whole purpose of Project Air's existence, the idea that we can upskill staff at a baseline level, to be able to provide effective treatment without requiring extensive, even name-brand therapy approaches, that a lot can do.

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So yes, I think that's the counter argument, that's certainly possible. And that statement certainly is true.

CM It's a difficult one, isn't it? It's… And I'm wary that I'm giving you, leading you to a position of landing on one side or the other, so I respect your choice to remain in the middle, remain in the grey zone, or the nuance of it. Which I think often is what we need to do as clinicians, working with this population. Nick Bendit, what do you think?

NB I agree with Nick Day's point of view, and I think Project Air has done a lot to try and provide easier accessible tools and more common factor approaches to helping ordinary clinicians particularly rural clinicians. And the clinicians I see in mental health teams who were not trained in Borderline Personality Disorder might be in a bigger centre. But I think there are two levels that we need to think about. The first level is the everyday interaction that most rural mental health clinicians will do.

And I think that no matter what level you're at, whether you're in an emergency department seeing a patient in crisis, or a community team following up on a crisis, or you're working as a psychologist in a community team in a rural area by yourself, maybe with one other person… Wherever you are, if you adhere to the Joel Paris idea of listening and exploring the feelings and responding to that, you will do good work.

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If, on the other hand, you stay with your tried-and-true ways of dealing with them, in other words, try CBT, try to change their thinking, cognitive therapy, try and do medication approaches, try and do case management, or are hoping that hospital will make them better, all of that's going to fail. So I think, as a generalist, you can do really good work, as long as you're willing to tweak and change your approach. And usually, that requires some supervision. So I would argue, yes, you can do good work, and if you're going to have ongoing contact with the patient, get some supervision, and you'll do good work.

The second level is the one when you can't have, mostly, in community, which is the more specialised treatments, the name-brand treatments, which take longer. They're still essential. It doesn't have to be a particular name-brand, it doesn't have to be DBT, for example. I often get referrals to our service for DBT, and I say, DBT is but one of several models, and we offer two, we used to offer three models, and they're all equally effective.

So that second level probably still needs to happen. And if the client can't get to that, either through a digital therapy to a bigger service, or can't move, then you, as the generalist psychologist in a small country town, might offer that, but you'll need supervision with somebody who can help you with experience of ongoing work.

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CM Thank you. Let's say I was the mental health practitioner who didn't have experience in the brand-name treatments, but chose to work with someone with BPD on some of those common factors. Nick Bendit, what do you think is one piece of really practical advice that would be helpful to keep in mind?

NB I'm going to extend it to two pieces.

CM Great.

NB One I've already covered, which is that, that focusing on emotions and listening and responding to emotions and not getting hijacked by content, the story, the details. And as you said earlier, and I think it's true, the chaos will derail you, particularly with a currently crisis-driven patient. But the second one I would give you is a weird one, but I would say, you know it's like in crime novels, they say, follow the money. Well, in BPD, it's follow the love. The problem was created as caregiving difficulties, and fundamentally it comes down to a feeling of not being cared about and not being loved.

And the crises are always driven by some kind of push-away, or perceived push-away, by somebody who really matters. A partner, a parent, a child, a rejection experience. So again, it's a crisis of love, in caregiving. And then the antidote, the treatment, the common factors, is working on and managing and building a relationship of caregiving and love. So my second really practical point, but it's not that practical, is to think in terms of love rather than in terms of all their details and chaos.

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CM I really love that. In Schema Therapy, something that I've been taught in supervision, is to consider what would a good parent do in this situation? And I think that can be really relevant and really helpful for working with people with BPD. Because that can include things like providing love, and also providing limits.

NB Yes. I actually think your answer's better than mine, so we'll go with yours.

CM Oh, you set me up for it. Nick Day, what would your practical advice be for a generalist mental health clinician working with someone with BPD?

ND Yes, probably rehashing the same old round as what we've all been saying, but there's a human problem and there's a human solution. And so the therapeutic encounter has everything there for recovery to begin, or a healing process to begin. And so, again I think we can really complicate treatment of personality disorders, but Project Air, those key principles that we hammer home all the time about treatment of personality disorders, it's just things like being compassionate, demonstrating empathy, validating. And that has a profound impact, you know.

And when I think about it, again we were talking about the common or the core difficulties, or regular challenges of Personality Disorder, thinking of something like abandonment anxiety, it's a key feature of BPD. A therapist who shows up to a session on a regular consistent basis, communicates clearly when they're going to be taking leave, talks about how they feel about breaks between sessions and things like that, that may be the first time that somebody has experienced that in their life, with someone who's meant to be looking out for them.

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And so, people may not think that that's the kind of treatment factor, but it often can be a really powerful tool in promoting recovery. Those kind of things can be thought of often as the things that you're needing get in the way, get sorted before the treatment can occur. But it's actually, that is the treatment in a lot of ways. So, in a lot of ways it's simplifying things and just being human and talking about their relationship, and demonstrating empathy.

CM We've been talking a lot about the caregiving relationship and how… I guess that's what the therapeutic relationship should really mirror for people with BPD. Something that we often hear is that, in rural or regional areas… And this can happen in metro areas too, but perhaps more often in regional areas, there's a lot of turn-over. What do you think we could do if, say you know that there's a lot of turn-over in your team, and that realistically, you might only be seeing this person for a couple of months? Can you establish any sort of caregiving relationship within that time, or does it have to be a longer-term thing?

ND When we do, at Project Air we do work in schools. And in a school counselling setting as well, there's even, it can be a once-off, you get one chance. They come into the counsellor's office and they go, and you never… Because of the chaos of the school. And to be even more radical about it, is that you could even, if you have one opportunity and one touchpoint of connection, that can still be enough to generate, to start a process. So, in a really short time, it doesn't have to be long-term therapy. Long-term therapy, I'm of course an advocate for, and has a profound effect. But really short-term therapies also are profound as well, and can really have a remarkable impact.

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CM Yes. Nick Bendit, what do you think?

NB Yes, I'd say much the same. I see a lot of patients, and the patients we take in to our service are pretty severe, they're people that have been behaviourally really out there and out of control. On the other hand, they're usually settled enough,

at least, to come to psychotherapy. So, having said that, I hear a lot of times the patients say to me, because I used to do many of the introductory interviews, and the entry gate into our service… And I would hear a patient say, my life was just spinning out of control until one night when I was in hospital, one of the nursing staff sat down and listened to me at midnight, held my hand and asked me what was really the matter.

And rather than try to solve my problems, actually listened to me. And I thought, okay, and they say this was a turning point. So I agree with Nick, those one-off things can be turning points, they can be powerful. But I don't think they're the treatment. I think they're the turning point that then is a basis for them believing that a treatment is possible. And that's what they mean by the turning point. Then they've got to do the hard yards, and that's the consistent work. And I don't think we have any evidence that any treatments under six months really are effective for BPD. It is a sustained thing, but that doesn't negate the short-term interventions that are so important in setting that up to be successful.

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CM I imagine if you had something that was that transformative, that might really change your self-concept and your perspective on hope, and the hopefulness that you feel, which might actually prompt you to be able to have the capacity to engage in longer-term treatment.

NB Yes.

CM Yes. Thank you for that answer. That's, I think, really helpful. So, we've spoken a little bit around risk. Nick Bendit, you've mentioned the Joel Paris approach of going slow with risk, not over-reacting, not over-responding. And Nick Day, you mentioned that risk is something that's often at the forefront of clinician's minds. Often, suicidality in particular, and self-harm, is a real challenge for people with BPD, and I think it can often lead to high levels of clinician anxiety, as we've touched on. Knowing that suicide prevention is a whole topic that we can't really get into in detail, Nick Day, what would be your top piece of advice for managing risk concerns collaboratively, with someone with BPD?

ND Yes, I have to say, when I speak about this, this'll be couched in terms of my therapeutic style, which is Transference Focused Psychotherapy. But I think, as we've been talking about, there's common elements here. In TFP, we talk about something called setting a contract. But I think a common language is setting a frame for understanding and talking about and managing self-harm and suicidality. And, as I was saying before, that again these are things that we might think of as need to be sorted out so the real therapy can begin.

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Talking about this is also a part of opening the door for effective therapy to take place. So, you said, Caitlin, you mentioned anxiety, right? I might even use that in setting the contract, or setting the treatment frame. I might say to someone who has severe self-harm, suicidality, in setting up a treatment with them, that in order to be an effective therapist for them, I need to be able to think freely. And when there's a lingering threat of suicidality, of self-harm, and that seems out of

control, I can't think freely and I can't help you with the therapeutic work.

So we need to come up with a way to manage that, so it doesn't interfere with what we're trying to do in the treatment. And then, and that's kind of inviting them in to talk about their suicidality and self-harm in a way that's non-punitive. It's not a, you need to do this or you're out, kind of thing. It's explaining why that's a really important thing that we need to figure out a way, mutually, that we're going to try to work on this together so we can get some important work done.

That can be things like trying to control the urge and coming in to treatment and talking about it together, or it can be going to the Emergency Department when they feel like they can't control their urge. Or, coming to session, what would happen if they come to session and they're acutely suicidal, and I need to call an emergency, call an ambulance or something for them. Really in clear details, talking about what happens in what situations and what will happen after that, so we both have a really clear understanding.

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So that's the set part of the contract, but I should also mention that's a discussion that I just have with patients when I am setting things up. But again, Project Air has care plans, there's safety plans, there's things that… There's treatment tools and resources that people can use to also make that much more explicit and have it down on paper to make it a bit easier to have that conversation as well. But that's certainly something that I do in trying to manage this.

CM Yes, okay. Thank you. And Nick Bendit, what do you do to manage risk with someone with BPD?

NB Yes, following up on what Nick said, the fundamental thing the treatment does, and any intervention does, in order to make the person feel that suicide is really an alienation experience. It's really an experience that there's nobody out there in the world understands or cares or can help me or wants to respond. Now, as soon as I connect with them, and again, this can be in an emergency department, with your mental health team, GP surgery, or a therapy relationship, then as soon as I know that I'm actually listening to what their emotional suffering is, and responding to that in a way that makes sense to them, the risk goes down, most of the time.

So my first approach, when faced with someone with BPD with an acute suicidal crisis, is to try and settle the crisis by understanding the emotional experience and forming a bridge and a bond with them, around the experience of wanting to die. And that, more often than not, brings it down. If I rush to a suicide plan, what I do is put them on one side and me on the other, and instantly they feel more alone, and usually more suicidal. So, paradoxically, most suicide plans, at least rushed into, are counter-productive.

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The difficulty is that when someone says, I want to kill myself, it makes us scared, and it should. We would be inhuman not to be anxious about that. But the difficulty is that anxiety makes us want to stop the threat, so we want to jump in there and do something to bring down the suicidal risk. And that's exactly what I

try not to do, right at the beginning. I try and listen and explore and understand, just like Nick said, in the therapy. Try and talk about this, and get in together and understand them.

Then, at the end of the assessment session or the therapy session, if I'm still worried about them, then I'll move to looking at what do we do on the outside, what kind of things can you do to manage, what kind of things can I do to help you, and what kind of professional things can be done. But that's my last resort. Now, my last bit on that is, within that, I much prefer to, if I'm going to do something to increase my level of support, because I think that connection is going to bring down the suicidal risk, better than putting them in hospital.

Hospital is my last resort, and I only use it when, firstly, the session with them hasn't brought down the suicidal risk, and then secondly, extra connection with them, like phone calls or an extra session that week, or something like that isn't helpful. It is much better… Sorry, I know it's a long answer, but it's an important area. It's much better for me to do it, it's much more effective than if I get a Community Mental Health Team person to do it, particularly somebody who doesn't know the patient.

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The other problem here is that, if you're following up, and in this case I'm following up, we are carrying a high level of risk. And some people can't do that. And sometimes I can't do it, I want to have a relaxed weekend, I don't want to be worrying about my client all weekend, and I will use hospital for that.

CM Yes, and I think that's entirely reasonable, and good to know where your limit and line in the sand is as well. So it sounds like what you're saying is that you need to contain your anxiety, so that you can remain curious to sort of foster the connection. And the connection is what's going to actually bring down the suicidality, because the suicidality is around feeling isolated and alone, and like no-one gets you.

NB Just in terms of the crisis call, so you'll have clinicians who are taking crisis calls. And I think there's a three-stage response that's needed from the clinician. And often the clinicians will do one of the three but not all three, and the three are important. What the clinicians will often do is offer some strategies. And usually, they've now been influenced by DBT strategies or other CBT-type strategies. And the strategies are only one part, and by themselves, not that helpful, even though I'm a DBT practitioner and a Psychodynamic practitioner.

The other two bits, the first bit always for me is the Paris thing, of listening to and understanding the emotional experience, because that settles the patient already and builds the bridge for what comes next. I had a call like that last night, a woman sobbing, terribly distressed, wanting to kill herself. And the first thing I did was I didn't spend long, maybe two minutes, just hearing the context, what it was about, the cousin who is the main person in her life, they had a big fight and told her that she hates her. Terrible for her.

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And so I listened to that and she settled a little bit. The second step was to give

her some practical things to do, because she was really angry and she wanted to go and kill the cousin. So I wanted her to be able to do something with that energy, so I said to her, do something vigorous. Go for a run, do some star jumps, think of something. She said, no, no. What about dancing? No, no, no, no. And then she said lifting weights, and I said, fabulous.

So she lifted weights, and then I said the third bit. And this is the bit that's often missing in the crisis call, is I said, ring me back when you've done those things. And if I'm worried about the ring back, then I'll say I will ring you back in an hour. And that third bit is probably the most important bit, and that's often missing.

CM And why is that bit so important?

NB Because it's the thing that says, it really demonstrates in a procedural way, a really tangible way, I care about you.

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CM I care about you and I still want you to be around in an hour.

NB You're in my mind in this crisis. Rather than, you've talked to me, I've done the job, and I've disposed of you from my mind, I don't really care.

CM I think that's such a powerful thing, and it isn't something that we often do or offer. So, when you're working with these complex and often high-risk individuals, sometimes mental health teams can experience what we call splitting. Nick Bendit, can you start by telling me what splitting is, and if you've experienced it, what it felt like for you?

NB Yes, I've certainly experienced it. Anyone who's worked on a mental health ward has experienced it. And I'll give you an example from the team I supervised yesterday. It's a drug and alcohol team, and they had two, they're running abstinence for alcohol groups. And one of the patients is really struggling with her abstinence. And so one of the trainers, one of the group leaders, is kind of feeling this poor person's trying, we should let her come into the group, even though she's drinking. Yes, it's not a good look for the rest of the members of the group. And it is a client with BPD as well.

And the other trainer was thinking, this is a terrible, unfair, bad deal for the group, we should kick her out and tell her to come back when she's abstinent. That's splitting. Now, what's often mistaken, misunderstood, is this is not something the patient's doing to us. They're not Machiavellian, master manipulators who are playing us off against each other. Because that's how it feels, we feel like we're being played off against each other. Really, it's just survival. These clients have learned, in their families, that to go and directly ask for their needs and to show vulnerability is dangerous, it doesn't work.

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Asking for your needs or showing vulnerability often leads to terrible outcomes. So they've learned to do things, to find the person that might give them what they want, and to stay away from the person that scares them. So in a mental health ward, what inevitably happens is, instead of going to the nurse who hands

out the medication, but who seems a bit more forbidding, they go to the nurse they like and get on well with, and say, can I have some Valium tonight because I can't sleep, and I can't go and talk to the usual nurse because she's scary.

And that then sets them off against each other. And I think it usually works this way, but it's actually a simple solution. It's a terrible dilemma, but often a simple solution. I get the two nurses in the same room together with the patient, and somehow, I just get them to talk about it. And somehow, the hard-arsed nurse becomes softer, and somehow the soft, permissive nurse becomes a little tougher. And the patient somehow starts to figure out a solution that can include both of them.

CM What do you think the active ingredient is, in getting them in the room together?

NB Magic.

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NB I think it's that thing of, if they can make it safe enough, that old thing of not talking to one and talking to the other, and therefore setting them off against each other, gets broken down. And everybody gets in the discussion, and that then enables a joint solution for everyone in the room.

CM Yes, okay. So you need to communicate and understand everyone's perspectives.

NB And the safety is the critical thing to allow that to happen.

CM Yes. Thank you, that explains it really well. Nick Day, what about you? Have you ever experienced the feeling of splitting? And I like what you said, Nick Bendit, around how often it's talked about as if it's the client's fault, but I think that's quite a pejorative and quite punitive way to view it, when often it's actually the interactions of the health professionals and our own stuff coming up. What do you think? Have you ever experienced splitting, and what did it feel like for you, and what happened?

ND Actually, my first reaction is maybe a bit tongue-in-cheek, but yes, of course I've experienced splitting. I think all of us have, personally, any of us who have been in love with anyone, when the other person was totally perfect and they fulfil all our needs, and then over time they became a human with a mind that we couldn't totally understand and had different wants and desires than our own. Any of us who have been a child who had parents that were powerful and could do everything, and we looked up to, and then we matured and we realised that they're kind of just humans and they're really fallible in all these ways.

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Like, any one of us who have been through those experiences, have experienced it, really, on a personal level. So, it's a deeply human thing and we can empathise with it. In therapy I've experienced it, personally, in terms of… And I can understand it, when I, the therapist, have let down my patient in some way. I haven't been attentive, I've misunderstood what they've said or I've been late to a session or something like that. And the split occurs, and it feels in the room,

suddenly, there's questions about my intentions, my ability to be available, all of that.

And it's totally understandable, someone who is being depended on is fallible. How fallible are they? It's a scary conundrum, and splitting is a simple solution to that conundrum. But it also happens within teams, as we've been talking about, at all levels. We've talked about the medical systems, but also within schools, within family systems, thinking of working with adolescents.

Just to give a practical example, in adolescence, parents are powerful, adults are powerful. The therapist is typically an adult, the therapist is typically on the side of the parents, then there's a split between the young adolescent and they're suspicious of the therapist, what's their true intention, are they really here for me or are they here for my parents and they're controlled by my parents in the same way? Or, within parents too, to young people as well, parents that are really seeing their child struggling tremendously and feeling a lot of guilt about that, and maybe want to communicate to the therapist that it's not their fault.

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There's something wrong with their kid, the badness exists in the kid. And so all of these splits occur, and the parents want you to side with them against the kid, and to kind of get them into line, in a punitive way. These are all splits that can occur within treatment teams that need to be addressed. And I think it's exactly what Nick Bendit said as well, collaboration, getting everyone in the same room is how you address it.

But also supervision, which is something we've said a lot throughout today as well, or just getting supervision to help understand these processes when they're happening. And, if I could be so bold, even individual therapy can be really helpful for clinicians that are trying to understand. When it happens, it can be really destabilising, really profoundly upsetting to be seen in all these different ways and to be drawn into what's happening in the treatment. And personal therapy can also be a really effective tool to help understand your own processes and help manage it.

CM Absolutely. I think, in my own experience, supervision in particular has been so helpful at identifying what is my own reactions, and what of my own personal experiences are contributing to this. And, I guess, almost feeling like you are less caught up in the waves of the emotional turmoil, and being able to ground yourself and get a bit of distance from it, to be able to see clearly.

So, we've spoken today about understanding BPD, and some of the challenges that come up for practitioners and for clients. This is an area that many practitioners might choose not to work in, because of some of the complexities and the challenges that we have spoken about today. Nick Bendit, I'm interested, why do you work in this area?

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NB Well, that's a big question, and I'll try and be very brief. I think, fundamentally, I like to get close to people and work with them on what is authentically important to them. Not what society deems is important, but what is personally valuable

and important to them. And there are no better clientele to work with than this, because these folks are desperate to share that internal world with somebody who is not frightened of that and wants to engage with that. So, when it works, it's a mutually fantastic experience.

It's arduous and difficult and worrying, and all of those things, but if you want to connect with someone else, this is what this is all about. So that's fantastic. The other thing that I think is the reason I work in this area, and I've worked in general psychiatry and I've worked with people with psychosis and head injuries and drug and alcohol, is, believe it or not, these folks get better faster than all of those. All the other, many of the other areas in general psychiatry. And given the right treatment, and both them and you being in the right place to work on this stuff, they change, but most of our clients, if they're there to work, as Nick was saying earlier, the improvements are really powerful. So that's why I love working in this area.

CM Wow. Thank you. Nick Day, why do you work in this area?

ND Probably for a lot of the same reasons, to be honest. I think, Nick, you said authentic, I think was the word you used, and for me, I was thinking real, it's real.

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The work, it's… When I was talking before about self and other functioning, I was saying this is the essential elements of life, as in, I'm in that, I'm living life myself as a human. And so, what's that kind of great quote, nothing that's human is alien to me, so everything that shows up in the room is a part of, I can understand and empathise with. The transformations that you can see are major, but it's a mutually transformational relationship, when it goes well.

I was thinking about, I haven't done an official kind of audit, but I imagine if I thought about all the patients I've seen, and the ones that had an impact on me, the ones that I still think about and that kind of helped me think about myself in my own life, it's patients with a diagnosis of Personality Disorder, rather than patients with a diagnosis of Bipolar, or ADHD or depression or anxiety or something like that. It's a really enriching and interesting work to do, so yes, and I really enjoy people with a diagnosis of Personality Disorder. So I really enjoy it, it's challenging but it's really invigorating at the same time.

CM Thank you. All right, so, if listeners of this podcast were to take away one thing from this episode, Nick Day, what would it be from you?

ND It would be that therapy can help and can make meaningful changes in people's lives. And that while working with people with Personality Disorder could be challenging, simple things can make a major difference. And that not only is a recovery from BPD possible, it's likely.

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CM Beautiful. Nick Bendit?

NB The thing I've been hammering all the way through, and I think Joel Paris's point that as a clinician, if you can change your orientation from the usual things we

do, and trust that exploring the patient's emotional world and understanding and responding to that, whether it's a one-off session or whether it's a full therapy, you're going to do good.

CM Beautiful. Thank you. Okay, that's all we have time for on this episode of the Peregrine Rural Mental Health podcast. Thank you for joining us and sharing your knowledge, Nick and Nick. It's been a pleasure to speak to you both about this important topic. I know I have learnt a lot, and I think our listeners will too.

NB Thank you, Caitlin.

ND Thanks.

CM For listeners that might want to know more about this topic, we have a practice guide on working with people with a diagnosis of BPD available on our learning platform on our website. And we will include some other resources there for you to dive into. Thanks for listening.

00:58:21

Outro I hope you found today's episode helpful. You'll find specially selected resources on this topic on our digital learning platform. To join the platform for free or to suggest questions or topics for further episodes, please visit our website theperegrinecentre.com.au.

58:54