PROJECT AIR
A PERSONALITY DISORDERS STRATEGY

Air Notes

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2015

IN THIS ISSUE:

"Inside Borderline Personality Disorder"

is the theme of the 9th Annual Conference on the Treatment of Personality Disorders 6-7th November 2015

A **lived experience** perspective will be provided by consumer and advocate Sonia Neale, from Western Australia. Sonia is the recipient of the 2014 SANE Hocking Fellowship, and has written extensively on Borderline Personality Disorder from multiple perspectives, including as a consumer.

A **professional psychotherapist** perspective will be delivered by Dr Dolores Mosquera. Dolores is the director of the Institute for the Study of Trauma and Personality Disorders (INTRA-TP) in Spain. Following the Friday conference she will present a one-day Saturday clinical workshop on "Borderline Personality disorder and complex trauma: Therapy skills for working with trauma and dissociation."

The conference and workshop will be held in the beautiful surrounds of the University of Wollongong, one hour south of central Sydney on the coast surrounded by rainforest. Details www.projectairstrategy.org

NSW GOVERNMENT Health

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Sonia Neale

Dolores Mosquera

UNIVERSITY OF WOLLONGONG

Focus on Lived Experience

My BPD journey from Emergency Department to Recovery and Beyond

by Sonia Neale

Sonia Neale is presenting a keynote talk at the upcoming conference this November

Getting a diagnosis of Borderline Personality Disorder (BPD) is not universally received with joy and gladness. It can make you crumple to the ground in despair at such a stigmatising diagnosis or it can help you pause to think about what this really means. Some will embrace this with relief and research and others will reject it with anger. It is what the diagnosis means to the person receiving it that is important. Neither response is right or wrong. I found it personally empowering, but not everyone does.

Where the diagnosis is especially important is at ground zero, the Emergency Department, where a compassionate mental health professional can make the difference between life or death, self-harm or suicide. At that point in time mental health professionals have the most extraordinary power to make or break us. Some can use the diagnosis as exclusion criteria for people who are unwell. It's like being a trauma victim of a car accident and excluded from treatment because you are bleeding all over the treatment room. It does not make sense to be harshly shunted out the door for displaying the same behaviour that got you diagnosed in the first place.

There are many different presentations of BPD, some are quiet and compliant, some are self-harming, some are highly volatile with raging interpersonal issues, some have highly successful careers, some do not, some are psychiatrists and some are motor mechanics. BPD does not discriminate between education, employment and socio-economic status.

I was the quiet and compliant BPD presentation. I functioned well until I didn't. My first admission, when my third child was eight months old, was in 1996. I had previously been diagnosed with postnatal depression and I was never told of an alternative diagnosis until I self-diagnosed in 2004 after reading an article on the internet. It fited me like a glove and it was a huge relief to be able to put a name to my dysfunctional life. It is not rocket science to know you fulfil the nine DSM criteria.

In 2005, my life was not functioning due to adverse circumstances and I was depressed and anxious and went to see a GP practice, who over the course of several weeks prescribed me with an anti-depressant, a mood stabiliser, an anti-psychotic, another anti-depressant, a benzodiazepam and a highly controversial sleeping tablet. Not once did I disclose the adverse circumstances and not once was I asked what was happening in my life at that time. It was situational rather than systemic.

I ended up in a private psychiatric clinic poisoned and highly toxic due to so many legally prescribed drugs in my system. I had all the side effects and none of the benefits and I was a gibbering mess, physically and emotionally. The psychiatrist noting my distress increased my anti-psychotic and told me I had a personality disorder. There was no discussion. I did not ask him which one. It felt demonising, and I felt he was repulsed by me. When I read in a letter to my GP I had BPD, I was angry with him for not explaining this to me. It felt disrespectful. I have later spoken to this psychiatrist and he was deeply caring and concerned about another issue I had. I am prepared to consider that my perception may have been skewed at the time.

My previous three hospital admissions, 1996, 2003 and 2004 were completely different. I was not on any prescribed drugs and I found the respite from my stressful perceptions of life gave me pause to learn CBT skills which were fun and educational; but I was unable to transfer them outside of hospital. It took nineteen years of supportive psychotherapy from a very nurturing but challenging therapist to help me understand the connection between my thoughts, emotions, perceptions and subsequent behaviour and responses with the people I interacted with in my daily life.

I now work in mental health services. No-one wants to go to ED in a mental health crisis; no-one wants to live their life out of control. Everyone is doing the best they can under a personal crisis. Being told by indifferent staff, "Not you again", "Collecting more frequent flyer points are you", "She/he is "known to services" and my all-time favourite said to a client of mine I advocated for, "We will have to do something for this bad mood you are in," is not only not helpful, it is highly damaging to us as human beings.

Being treated with respect, care, compassion, empathy and dignity and having someone ask gently, "What is happening for you at this moment," is not only validating our experience and feelings, it is valuing us as people of the human race. People who, rather than having a lack of moral compass and a negative attitude, have a genuine, recognised mental illness for which there is not only treatment, but the hope and expectation that the treatment will work, and that people can and do recover from Borderline Personality Disorder.

I know because I am one of them, and I have also seen it work for others as well.

Dr Dolores Mosquera talks about working with complex trauma and personality disorder

Project Air Strategy caught up with Dolores Mosquera, psychologist and psychotherapist specialising in complex trauma and Borderline Personality Disorder. Dr Mosquera is presenting a keynote talk and workshop at the upcoming conference this November.

Working with complex trauma and Borderline Personality Disorder often involves the ability to understand the apparently out of proportion reactions of our clients. For Dr Mosquera, this challenge can be overcome through the familiarity of our clients' traumatic history. Conceptual frameworks like the Adaptive Information Processing model, Attachment Theory, and the Theory of Structural Dissociation of the Personality enhances our ability to recognise the manifestations of these reactions. Furthermore, she states that "it is important to realise that unresolved issues may function as triggers when working in the here and now. In turn, apparently neutral stimuli become cues for clinicians in session - all helping for both therapist and client to understand what is going on".

Indeed, Dr Mosquera stresses "the importance of identifying and understanding the internal conflict that many of our clients face". She believes that this is related to the lack of integration observed in Borderline Personality Disorder. "Dissociative responses can be due to chronic traumatic experiences that lack attachment repair. Dissociation, and therefore these dissociative responses, may be maintained due to internal conflict, lack of integration, lack of realization, and lack of social support. An understanding of these concepts helps the case conceptualization and treatment plan".

Internalized messages from abusive figures can be carried around in client's minds, triggering low self-esteem. "This would explain why they are so rooted and difficult to change. Clients tend to look at themselves through the eyes of the abuser. A fragile identity usually goes hand in hand due to inadequate exposure to mindsight, support and attachment repair. When clients do not have the experience of being looked at with love and acceptance, their identity is profoundly affected and shame becomes a primary dynamic. It is therefore difficult for clients to change the way that they see themselves without repairing the attachment system. Many psychological problems are also created by the cumulative effect of unresolved traumatic, adverse experiences and attachment disruptions. Therefore it is important to explore and consider the experiences that influenced how the person learned the behaviour or symptom" said Dr Mosquera.

If primary or secondary caregivers during critical periods of development were absent or chaotic, it is easy to understand the difficulties our clients had growing up. Similarly, impulsive reactions do not seem as impulsive if we understand the triggers and how they are conditioned responses to previous, unresolved trauma. By understanding triggers, we can work with the issues that are generating apparently impulsive reactions in the here and now.

Dr Mosquera pointed out that the concept of trauma keeps being interpreted as an 'all-or-nothing' phenomena. For many professionals, patients, and family members the word "trauma" is only equal to "sexual or physical abuse". The concept of trauma is in fact much broader, and at times, much more subtle. She notes "In childhood, many perceived threats stem from the caretaker's affective signals and lack of availability. In comparison, the actual level of physical danger or risk for survival is less frequently the cause of trauma. These 'hidden traumas' are related to the caretaker's inability to modulate affective dysregulation." As we know from work of researchers such as Schuder & Lyons-Ruth (2004) verbal abuse by caregivers (and bullying) create as much, if not more psychological problems in later life than physical abuse. Ultimately, Dr Mosquera reminds us that "trauma is the subjective experience during or after a potentially traumatizing event. This therefore does not imply over inclusion or the labelling of any upsetting event as traumatic".

In relation to Borderline Personality Disorder, presenting symptoms are similar to the common known consequences of early, severe and chronic traumatization. "In our clinic we often have clients with BPD present with memory loss (amnesia) of certain time periods, events and people, a sense of being detached from the self, depersonalization, derealisation, perception of people and things around as distorted and unreal, a blurred sense of identity and hearing voices. Often our clients will not talk about the voices they hear due to the fear of being considered crazy. In turn, not working with these internal voices tends to maintain our client's internal conflicts" notes Dr Mosquera.

"By understanding the nature of internal conflicts clinicians can adapt the interventions to the client's needs. This allows clinicians to structure their work, and follow the client's rhythm" said Dr Mosquera.

Dolores Mosquera is the director of the Institute of the Study of Trauma and Personality Disorders (INTRA-TP), Spain and will be giving a workshop on 7th November 2015.

Read more:

Mosquera, D., Gonzalez, A. & Leeds, A. (2014). Early experience, structural dissociation, and emotion dysregulation in borderline personality disorder. Borderline Personality Disorder and Emotion Dysregulation. 1:15

http://www.bpded.com/content/1/1/15

New resources on parenting

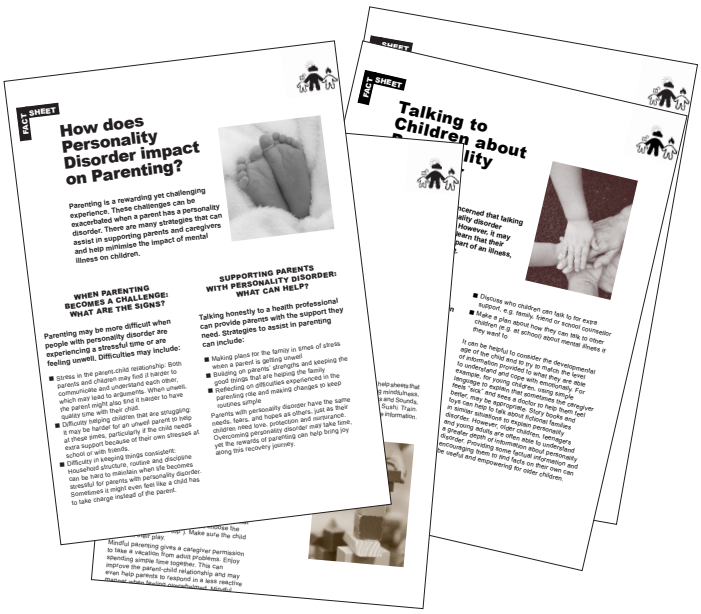
to be launched in November at the 9th Annual Conference on the Treatment of Personality Disorders

Project Air has been working with the NSW Health Ministry's MH-Children & Young People to develop resources to assist clinicians working with clients with personality disorder who are also parents

This work has been guided by Tania Skippen (A/ Director) and Noha Sutton (Family Focused Recovery Program Manager) with an advisory committee including Kylie Pillon (NSW Consumer Advisory Group), Dr. Scott Clark (Clinical Director of Mental Health Drug and Alcohol, Western NSW), Clair Edwards (senior nurse, Sydney Local Health District) and Bradley Morgan (COPMI Children of Parents with Mental Illness National Initiative Adelaide). Pilot work to test the materials has occured with more than one hundred and seventy staff from across NSW including Western NSW LHD, Murrumbidgee LHD, Southern NSW LHD - Eurobodalla, Mid North Coast, Central Coast LHD, Northern NSW, South West Sydney LHD, Northern Sydney LHD, Sydney LHD, South Eastern Sydney LHD, Nepean Blue Mountain LHD, and the Justice Health and Forensic Mental Health Network. The new resources to be launched can be viewed on the projectairstrategy.org website. Help sheets and fact sheets include topics such as understanding how personality disorder can impact parenting, talking to children about personality disorder, setting safe limits with children, connecting with children at different ages, strengthening attachment, mindful parenting, and understanding and responding to children's feelings. In addition, the Parenting with Personality Disorder Intervention Manual and the Parenting with Personality Disorder film are now accessible for early view.

Addressing parenting difficulties within the context of the mental illness can improve mental health functioning, reduce family stress and increase competence and fulfilment from the parenting role. This in turn not only improves outcomes for clients, but is an essential component in providing care and protection for children and young people. The prevalence of parental mental illness in Australia is estimated to be 21 – 23%. For children of parents with a mental illness, their risk of also experiencing mental health difficulties has been found to be as high as 41% to 77%.

Two new posters are also available for download from the projectairstrategy.org website, the Present Moment Poster, and the Parenting Poster.



VISITS AND VISITORS TO THE PROJECT AIR STRATEGY

Dialectical Behaviour Therapy DBT expert Alan Fruzzetti visits the Project Air Strategy in Sydney

Professor Fruzzetti visited the Project Air Strategy in June 2015, including providing two days of workshops in Sydney to local health workers and family members.

Professor Fruzzetti is a Professor of Psychology and Director of the Dialectical Behaviour Therapy and Research Program at the University of Nevada, Reno. He is on the Scientific Advisory Board of the Linehan Institute and is the co-creator of the NEA-BPD Family Connections program, for parents, partners, and other loved ones of people with Borderline Personality Disorder and related problems. He presented a workshop on "Advanced dialectical behaviour therapy skills for personality disorders: how to get in-session skills training into the patient's repertoire," and a second workshop on "Working with families and carers: strategies for supporting someone with personality disorder."

Professor Fruzzetti discussed how diagnosis can be confusing to patients, families and therapists, as each person with Borderline Personality Disorder can have a different set of problems and may often have multiple comorbid diagnosis. Professor Fruzzetti stated "to have an accurate assessment to classify Borderline Personality Disorder is actually quite hopeful. In 2015 for the first time we have multiple treatments that work, and that wasn't true even 30 years ago, so it's actually good news." Professor Fruzzetti commented that stigma "follows Borderline Personality Disorder around like a dark shadow." However, explained that "the differences between people with Borderline Personality Disorder and the people without Borderline Personality Disorder are actually much smaller than the things that we have in common. Everyone gets emotionally dysregulated sometimes. People with Borderline Personality Disorder get more intensively dysregulated more often, so carry with them more pain and suffering, but the nature of the dysregulation is quite the same as it is for anybody." Project Air's interview with Dr Fruzzetti is on the Project Air Youtube channel.

Project Air visits WHOS: We Help Ourselves – New Beginnings Program at Rozelle

WHOS is an organisation providing therapeutic programs aimed at achieving recovery from alcohol and other drug dependence.

The lifetime prevalence of drug and alcohol problems is estimated at 7.7% of the population in community settings. Estimates of co-occurring personality disorders in individuals with comorbid addiction range between 9.1% and 21.5% in the general population, however this rises to over half of clients seen in drug and alcohol settings. Project Air visited WHOS women's 'new beginnings' program on 17th July 2015 and met residents and staff, saw programs in action, and listened to how these directly help those in need. During the visit the Strategy also had the opportunity to provide professional development for staff to increase staff confidence, skills and knowledge about Borderline Personality Disorder in a residential drug and alcohol setting. Ongoing consultation on service and policy development in managing BPD and comorbid addictions and secondary consultation services on selected complex case reviews is progressing. The visit was hosted by Sarah Etter, Manager of New Beginnings and Jo Lunn who works on improving organisational capacity in WHOs.

Dr Nancy McWilliams visits the Project Air Strategy

Renowned psychotherapist and academic Nancy McWilliams caught up with Project Air on a recent visit to Sydney.

Dr McWilliams teaches at Rutgers University's Graduate School of Applied & Professional Psychology and has a private practice in New Jersey. She is an award winning psychologist and has authored many influential textbooks on diagnosis and treatment which have guided a generation of upcoming therapists. Dr McWilliams focus is on understanding internal experience to seek a richer understanding of the individual, in contrast to the behaviourally observed symptoms described in the Diagnostic and Statistical Manual for Mental Disorders. Central to this work is the importance for therapists to have an understanding of what it is like for a person to see the world in a certain way, using a person's internal experience to understand their behaviour and guide the treatment. For example, people with paranoid personality typically struggle with themes of trust versus mistrust, whereas people with obsessive personality are likely to struggle with themes of control versus lack of control. Psychotherapy is the treatment of choice for problems with personality because it works with issues of trust, capacity for collaboration, and understands emotions as information on how a person views the world and the experiences they have had in significant relationships. The individual differences between people mean that therapists need to understand and adjust their therapeutic approach. For example, paranoid clients may feel suspicious and threatened by a therapist who is too warm and affiliative, whereas depressive clients might respond to such an approach with relief. Project Air's interview with Dr McWilliams is on the Project Air Youtube channel.

Project Air visits the South Eastern Sydney Local Health District

Project Air visited Prince of Wales, St George, and Sutherland Hospitals in March to hear about the Gold Card Clinic and DBT personality disorder programs being implemented. Clinic coordinators Carryn Masluk (Prince of Wales), Andree Tatang (St George) and Peter Griffiths (Sutherland) lead the visit, and clinicians working in the clinics also used the opportunity to present complex care cases, including Wayne Borg, Peter Kelleher and Carryn Masluk. Project Air used the visit to also talk to staff about the latest research and updates on evidence-based care and treatment guidelines for personality disorder. The group lead a discussion on implementation issues, challenges and solutions to sustaining personality disorder-friendly clinics. Further visits are occuring across October to November.

Project Air delivers NSW Addiction Medicine Training in Liverpool

On the 1st April Project Air visited the Thomas and Rachel Moore Education Centre at Liverpool Hospital as part of a series of training provided for medical staff working in Drug and Alcohol services throughout NSW, aiming to improve professional development for doctors working in addiction medicine. Doctors in attendance were Trainees/Registrars, CMOs and Staff Specialists locally hosted by Dr Kathy Watson, Staff Specialist Psychiatrist, SWSLHD Drug Health Services. In support of the Addiction Medicine and Addiction Psychiatry training program Project Air presented on improving knowledge and attitudes about patients with personality disorders and comorbid substance use issues, with the aim of increasing a sense of competence and hope for treating clinicians.

Project Air visits Junaa Buwa! Centre for Youth Wellbeing in Coffs Harbour

Jesse Taylor (Manager), Dr Marianne Bourke (Project Air) with staff of Junna Buwa and Prof Brin Grenyer (Project Air, far right)

Project Air Strategy visited Coffs Harbour to Mission Australia's Junaa Buwa! Centre for Youth Wellbeing in partnership with the Network of Alcohol and other Drug Agencies (NADA).

Project Air visited the centre with manager Jesse Taylor and then spent two days with staff working in this residential rehabilitation service for young people with complex trauma, AOD substance misuse, and high risk behaviours during October 2014. Staff talked to Project Air about issues such as crisis management and care planning, working with challenging behaviours, understanding complex trauma, and engaging and supporting family and carers. Staff attending the meetings included youth workers, juvenile justice officers, alcohol and drug counsellors, psychologists and service managers who are currently working to provide residential rehabilitation services and substance misuse outreach programs to 13-18 year olds. The visit aimed to support workforce development, provide clinical practice guidelines and evidence-based practices supporting enhanced outcomes and a collaborative approach to service delivery.

Stay in touch and communicate with us

For more information on the Project Air Strategy, visit www.projectairstrategy.org
join our mailing list at info-projectair@uow.edu.au,

like us on Facebook, follow our Twitter feed and watch our work on Youtube.

Project Air service directory which provides information about personality disorder specific programs and clinicians is a popular part of our website and is used by many seeking further information and treatment options. If you would like your service to be included or details updated please contact us: info-projectair@uow.edu.au.

Keynote speaker from the 8th Annual Conference Professor Kenneth Levy interviewed by Project Air

Professor Levy visited Project Air Strategy headquarters at the Illawarra Health and Medical Research Institute in November 2014 and presented at the 8th Annual Conference on the Treatment of Personality Disorders.

Dr Kenneth Levy, back row, fourth from left, and some members of the Project Air team

Project Air's interview with Dr Levy is on the Project Air Youtube channel (youtube.com/user/ProjectAirStrategy).Dr Levy presented research findings on the treatment of patients with Borderline and Narcissistic Personality Disorders, and conducted a one-day clinical workshop titled 'Transference Focused Psychotherapy (TFP) for Borderline and Narcissistic Personality Disorders.' Dr Kenneth Levy is a Professor at the Pennsylvania State University and the Associate Director of Research at the Personality Disorders Institute at the Department of Psychiatry at Cornell University New York. Dr Levy discussed the conceptualisation of narcissism, explaining that often the overtly grandiose, pathological sense of self is the most obvious and well known aspect of narcissism; however, researchers and clinicians now also recognise the vulnerable side. Dr Levy explained that "the grandiosity that you see in narcissistic individuals serves a defensive function against the vulnerability and feelings of smallness." Dr Levy stated that research on subtyping Narcissistic Personality Disorder helps us understand these grandiose and vulnerable tendencies. "In reality, there are some people who might be predominantly grandiose or overt in their narcissism, or people who are predominantly vulnerable or covert in their narcissism, but typically people vacillate between the two" Dr Levy stated. The Diagnostic and Statistical Manual of Mental Disorders has typically focused only on the overt grandiose states as the defining feature of narcissism. Dr Levy predicts that based on the current research, future versions of the DSM will move towards recognising both grandiose and vulnerable aspects of narcissism as "two sides of the same coin."

Project Air expands across New South Wales Local Health Districts

In January the NSW Government announced further funding for a statewide rollout of the Project Air Strategy for Personality Disorders. The NSW Health Ministry's Mental Health and Drug and Alcohol Office leads the Project Air Advisory Committee, which is co-chaired by Dr Murray Wright, NSW Chief Psychiatrist and A/ Professor Adrian Dunlop, Chief Addiction Medicine Specialist. Local health staff will work within the strategy to implement new programs and approaches to create personality disorder-friendly services, smoothing pathways into brief and longer term psychological treatments shown to work. The NHMRC (2012) treatment guidelines specify characteristics of quality services and practices, including early detection in young people, implementation of evidence-based psychological therapies, and offering support for families and carers. Changing staff hopefulness in treatment, providing them manuals and guidelines to work in specific ways, and attending to complex care issues is part of the support provided. In addition, clients' needs vary therefore attending to specific issues is important, including such things as enhancing parenting skills, attending to addictions and using strategies to assist reduce self-harming behaviours. Project Air is currently rolling out in Northern Sydney LHD and will expand to additional LHDs. The next LHDs after Northern Sydney are South Western Sydney and Central Coast.

www.projectairstrategy.org

The Project Air Strategy acknowledges the major support of NSW Health. The Project works with mental health clinicians, consumers and carers to deliver effective treatments, implements research strategies supporting scientific discoveries, and offers high quality training and education. Contact us at info-projectair@uow.edu.au or visit www.projectairstrategy.org

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