



BPD COMMUNITY

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The newsletter of
BPD Community Victoria Ltd.



To join our email list, email:
barb@bpdcommunity.com.au

A sense of community is created through shared experiences and a common concern. We hold a common vision for a world without stigma and discrimination in relation to BPD. Our Information Nights are an opportunity to meet each other, to learn up to date information in relation to BPD and to share the company of others who have the same vision as ourselves. It is through shared experiences that we create community, all are welcome. See you there!

Strength in diversity and shared experience

Diversity is the art of thinking independently together. No, this is not an oxymoron but a deeply philosophical commitment that underlies BPD Community. We are such a diverse community on many levels and we are united in a common purpose with a common vision.

We are proud of our diversity and would like to extend our sense of community to include even more difference. We are a community of young and old, all sexualities and genders, from many different cultures, from all walks of life. We are working together to make a difference, to make change in the world of mental illness, in the world of BPD.

Our purpose is to create a sense of community that supports recovery.

It has been commented on frequently that treatment in itself is not enough, that for the person with lived experience of BPD, they crave the support from being with others who understand and support their own personal journey to recovery.

Family members of those with lived experience gain strength and encouragement in exactly the same way. The sense of support that comes from being with others who understand and are able to support their own personal journey of acceptance and change.

Of course, for those who work with BPD and those affected by it, it is a challenge that is made easier with the support that being a part of a wider community who understands, brings.

Our mission is to replace stigma and discrimination with hope and optimism. With a strong community to give voice to this, we can create and have created change.

It is the strength of the personal relationships we all have with each other that strengthens our community. It is our shared experiences that build upon this. This is how a diverse community such as ours can change stigma and discrimination to hope and optimism.

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Yes, recovery is possible

It seems that we cannot say this enough: recovery is possible, it is a realistic goal.

What prevents recovery?

First and foremost is the still common belief that BPD is untreatable. Of equal importance is the belief that BPD is not a legitimate diagnosis.



Then there is stigma.

Then there is discrimination.

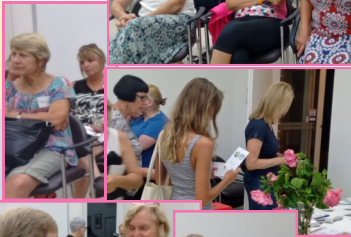
The good news is that there are good people working to bring about change. BPD Community is full of good people who want to create this change and the more who join us and become actively involved, the better chance we

have to make a difference.

It is through unity and being organised that we can make a difference for ourselves, our families, our fellow mental health professionals and others.

If you want to join us, email:
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It was a night of animated and thoughtful discussion.



Should we change the name?



Prof David Castle

Well! What a challenge that question creates. At our last Information Night, Prof David Castle both asked that question and challenged his audience.

Over 20 people including those with lived experience, family members and workers forgot about the heat for an hour or so and listened, thought, questioned and discussed this vexed question.

The Professor gave us an historical perspective on the stigma and discrimination that exists. It was very helpful to appreciate that so many of those in

practice today, the psychiatrists, psychologists if taught about BPD, were taught there was no treatment (treatment has been available since the late 80's). It is helpful that this is no longer the official message, however, it is this history that underlies the stigma.

The other factor in working with people with BPD is the difficulty of diagnosis. Prof Castle referred to the blurring between different mental illnesses and the confusion that can occur with co-morbidities. Co-morbidity

is a common feature of BPD as we all know. Commonly Depression, Anxiety, Narcissistic PD, and of course Drug and Alcohol Disorder occur with BPD.

Prof Castle suggests that his profession should just get on and treat the symptoms and not be fussed about giving a name to a diagnosis unless it is warranted or wanted by the person being treated.

The audience of various different points of view, were challenged by Prof Castle to see the position from a psychiatrist's experience. We were invited to understand a different perspective.

Black and white thinking

In the world of BPD, we love black and white thinking. It gives us a sense of certainty. It helps us make decisions and eases our impatience with the complexity of the world.

When it comes to being given a diagnosis or not, many people with lived experience and their fami-

lies are desperate for the clarity a diagnosis can give. In 2015, the 'carers', the family and friends of those with BPD, within the BPD Community determined that getting a diagnosis was their number one priority.

With a diagnosis comes information, understanding

and treatment choices. Suddenly everything has a framework for understanding.

Many in the mental health professions do not give a diagnosis to the frustration of those affected.

There must be a way through this dilemma.

The Dilemma of Uncertainty

Prof Castle made the point that for the psychiatrist, the priority is to treat the symptoms. He suggests the practitioner needs to be flexible in their thinking and prepared to consider changing their thoughts on diagnosis throughout the treatment process.

The point was made that if a psychiatrist becomes certain, that it is

a dangerous position. Certainty breeds complacency, the professor suggested and complacency means thinking is narrow. It is important to be open to learning not just from your own experience but also from the experience of others, especially when supported by the evidence of research.

Herein lies the dilemma.

It is important for the practitioner to be open minded and to treat what is presented at the time; however, people with lived experience and their families want the certainty of a diagnosis and a treatment that is known to work.

It is good to know that the strength in the diversity of the BPD Community enables us to accept this particular dilemma and to work towards resolving it.



"Uncertainty is an uncomfortable position, but certainty is an absurd one." Voltaire

“One of the proposed changes to the DSM was to call BPD ‘Emotional Regulation Disorder.’”

Borderline Personality Disorder was first named in 1938, in USA. It was meant to give a name to the illness of those who were neither fully psychotic or neurotic but who straddled the border between the two. From the outset it was deemed as untreatable and the stigma associated with it began.

In the late 1980s Dialectical Behaviour Therapy was developed in USA. This was to be the first evidence based treatment to lead to recovery. Hope and optimism began to filter through.

The Diagnostic and Statistical Manual is developed in

the USA to define the various mental illnesses. Dissatisfaction with both the name of BPD and the criteria used to define it was very strong leading up to the last review of the DSM. Unfortunately, the decision makers couldn't agree and we are still stuck with what is agreed, is very outdated.

The DSM V identifies 9 criteria for a diagnosis of BPD of which a minimum of 5 is required for a diagnosis. This crude measure can be a challenge to use without prior experience of BPD to back up understanding.

One of the proposed changes to the DSM was to call BPD “Emotional Regulation

Disorder” with 8 features that describe the effect of emotional dysregulation.

USA is not the world, and while the mental health profession there has significant influence, there are alternatives.

The World Health Organisation draws up the International Classification of Diseases (ICD). They are preparing for the ICD11 at the moment. In this document, all Personality Disorders are identified as either mild, moderate or severe, depending on how they affect the function of the individual to manage in day to day life. Issues such as holding down a job, managing fi-

nances and such like help with this assessment.

How BPD is defined for us, often depends on the school of thought or philosophy behind the definitions. Important schools of thought that influence us here in Australia: Gestalt, Behaviourism, Humanistic, Cognitive and Psychoanalysis and Structuralism/Functionalism. The focus on redefining BPD as Complex Post Traumatic Disorder is probably in response to a different school of thought than the dominant schools of thought in USA.

One thing is sure though. Those of us who live with BPD know and understand what it means and most practitioners are eclectic in their views.

The origins of BPD

It is commonly accepted that BPD is a result of both nature (genetics) and nurture (upbringing, culture, experiences). Interestingly, neuroscience explains BPD differently.

There are strong objections to the use of the phrase Personality Disorder. We all feel that our personality is an insoluble part of ourselves, something intrinsic about who we are.

This popular understanding of the word clashes with the more scientific idea of the concept. No one wants to be told their personality is wrong.

In 2008, using the work done in neuroscience to explain BPD, in USA Dr Heller joined the debate leading up to the DSM V discussion. He suggested it be renamed “Dyslimbia”.

This is based on the understanding of the illness as a result of malfunction of the limbic system. The new name then focuses on healing not labelling.

The limbic system of the brain includes the amygdala, the emotion centre of the brain, the hippocampus which is involved in forming new memories about past experiences, and other areas also associated with motivation and learning.



Subsequent work indicates that the neural pathways between the amygdala and the pre frontal cortex (for logic and thinking), are insufficient.

Neuroplasticity allows change to occur and these studies are the basis of great hope.

Axis V is the level of overall function.

So, this enables a practitioner to assess a patient first and foremost on Axis I, then on the other Axes as appropriate.

We in the BPD Community can see how inappropriate this is.

With a strong BPD Community, we can have an influence in changing this practice and help our mental health system work with BPD and recovery, and eliminate stigma and discrimination.

And the Axis is...

The DSM Axis is important. This is where much of the challenge in getting a BPD diagnosis stems.

The DSM has a 5 Axis system to help with assessment. It purports to be designed to help provide a comprehensive diagnosis.

Axis I are illnesses considered as ‘Clinical Disorders’ and the principal disorder. Included here are Schizophrenia, Bipolar, Depression etc.

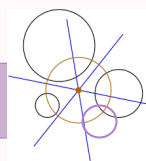
Interestingly, Axis I illnesses

as Clinical Disorders” are at the top level of mental illnesses.

Axis II disorders include Personality Disorders and Intellectual Disabilities. Axis II disorders are regarded as more permanent and not so responsive to treatment.

Interestingly, Autism used to be an Axis II disorder, but it got moved to Axis I, because some cases of autism are considered transient and can respond well to treatment.

In discussing Axis II in 2009,



it was suggested that the diagnosis BPD be changed to Adaptation Disorder: “...to reflect the real nature of the disorder...” (Svrakic, Lecic-Tosevski & Divac-Jovannovic 2009).

Axis III refers to the general medical condition of the person and any physical disorders.

Axis IV are the psychosocial and environmental factors, such as the family environment, that contribute to the disorder.

The Path to Recovery

Mental illness is not a choice, but recovery is...and we know that's easier said than done. Recovery is a journey, yes. So, how do we find the path to recovery and how do we read the signposts along the way? This is the topic for our mid-year Info Night.

For people with BPD, the journey to recovery is fraught with closed doors, dead ends and divergent paths. As people affected by BPD, we are challenged on many levels. The first problem is in understanding what causes the psychic pain, we might struggle to understand why our life is so challenging and painful. Gaining a diagnosis is often the beginning of understanding. Our next challenge is in finding clinical treatment—a psychologist or psychiatrist with whom we can develop a relationship and who can direct us to a structured programmatic approach to treatment. Will it be public or private? Who pays?

“Teach me how to live” were the words of Amanda Wang, a young woman from USA who has recovered from BPD and speaks publicly on her experience. After all, life goes on, there are bills to be paid, appointments to keep and all the issues of day-to-day life that are hurdles. People with lived experience, are often beset by the problems that come with years of inability to function on a day-to-day level. Chronic unemployment, ill health, debt and fraught relationships all need to be addressed.

Clinical treatment for people with lived experience of BPD is not enough. Support is needed to address the problems of day-to-day life. But what support is available and how do we access it?

Community services can provide a personalized approach for this sort of support. What is available? But how do we get to this part of the system?

There will be answers to all these questions at our next Info Night on Tues 6 June 2017.

Enthusiasm, commitment, passion.

Ilona Morrison is an Occupational Therapist at Inner South Community Health Service and has first hand experience of the challenges in understanding the Mental Health System.

As an Occupational Therapist, Ilona's work revolves around working with the individual to assess the challenges they face, and how they can achieve their desired lifestyle. Ilona will then develop a plan to support the person and implement and co-ordinate the plan.

Ilona works closely with her 'clients' to help them achieve their goals as independent, self-sufficient and balanced members of the commu-



nity. She helps them along the path of recovery.

Ilona says: “Recovery is not just about getting rid of symptoms, it is about living full and social lives, achieving our personal goals and enjoying what we do. Recovery is about living comfortably and loving well.”

There are many paths on the journey to recovery. Ilona will help explain them to us at our June Info Night.

TITLE: The Path to Recovery
PRESENTED BY: Ilona Morrison
TIME: 7pm
DATE: Tues 6 June 2017

PLACE:
Inner South Community Health Centre
341 Coventry St
Sth Melbourne

Please RSVP to:
barb@bpdcommunity.com.au