Talking to Change: An MI Podcast
Glenn Hinds and Sebastian Kaplan

Episode 31: MI in Borderline Personality Disorder Interventions, with Florence Chanut, MD, FRCPC

Sebastian Kaplan:

Hello everyone, and welcome to another episode of Talking To Change: A Motivational Interviewing Podcast. My name is Sebastian Kaplan and I'm based in Winston Salem, North Carolina, USA, and joined by my good friend Glenn Hinds from Derry, Northern Ireland. Hello Glenn?

Glenn Hinds:

Hey Seb, how are you doing?

Sebastian Kaplan:

Doing okay. We've been checking in with people given the state of the world. It is June 13th today. At least here in North Carolina, things are opening gradually, but North Carolina is actually one of the small handful of States that the country seems to have its eye on as far as, not necessarily a second wave, but an increase in coronavirus cases and hospitalization. So I think there's a bit of a mixed feeling about where we are. How about you?

Glenn Hinds:

We have continued to in our relaxation of the restrictions and there's a lot more going on. The shops have now opened while there are restrictions on them. There certainly is a feel that there's more of what was the old normal about and I suppose given the fact that we are talking about change, it's a bit to understand the mindset, the psychology of how we are experiencing this slow moving transition and our response to it. I would say that there's a lot more people being more willing to take the risk of not participating in social distancing and particularly with loved ones. Families are meeting up; friends are meeting up.

Glenn Hinds:

My youngest daughter is 19 and I would say that her cohort of friends, they have been meeting up, but I would say that social distancing is not necessarily being maintained the way it would have been before. I think the messaging we're getting from government is a bit more try and do your best, and that gives us a wee bit more leeway. The fear that probably was in the initial message has been removed and people are a lot more flexible with how they're interpreting what it is we're being offered.

Glenn Hinds:

And again, it's just being curious about that and recognizing as we witness ourselves and what those other people do in these things? This is human nature, and there's lots we can learn by just paying attention and just trying to understand why is this happening the

way it is. And if we were to try and change it, what would we need to do differently? And the way we communicate as we are here and in understanding Motivational Interviewing.

Sebastian Kaplan:

Yeah, it seems to be an issue of sustainability, sustaining change, and certainly in the States there's discussion of quarantine fatigue and how long can people expect to change their lives in such drastic ways, particularly when we live in areas that there isn't such an immediate threat as in places like New York City, for instance, where they've been much more used to stricter regulations or other countries like Italy, for instance, the issue of sustainability or change over a long period of time might be relevant in our discussion today. And so before we introduce our guest and introduce the topic, can you remind our audience the various ways that they can reach us on social media and other platforms?

Glenn Hinds:

So on Facebook, it is Talking To Change, on Twitter it's @ChangeTalking, on Instagram it's Talking to Change Podcast and for direct questions or contact with myself and Sebastian it's podcast@glennhinds.com.

Sebastian Kaplan:

Thank you, Glenn. And again, invitation for all our audience to rate and review us and leave us feedback and send us any emails with suggested topics and questions. We read all of it and discuss each and every one of them. Really excited about today's episode. We'll be exploring the role of Motivational Interviewing in working with people who have a diagnosis of Borderline Personality Disorder. And this is something that I've actually been really looking forward to for many, many months.

Sebastian Kaplan:

For those who don't know, I work in a department of psychiatry and many of the people we take care of, and certainly the psychiatry residents that I'm a part of training have to work with many people with this diagnosis. And it is a challenge I'm looking forward to discussion to sort of bring what MI can offer to working with this group of individuals. So, without further ado, we'll introduce our guest for today who is Florence Chanut. Thanks for joining us Florence, and as always, if you could start with just tell us a little bit about who you are and what you do, and also how did you get into MI?

Florence Chanut:

First of all, thank you very much both of you for inviting me, because it's a topic that I am really enthusiastic about. So yes, myself, I'm a psychiatrist based in Montreal. I'm an Assistant Professor at the University of Montreal. I'm trained in Addictions. I did a fellowship in Addictions at McGill University. At the end of my residency program I really noticed that everyday we're struggling with our patients on motivational issues on change, it's in every conversation with patients. And yet I didn't feel like I had really the skills to do a good job about that.

Florence Chanut:

And I noticed that when we feel powerless, we tend to use some not always very ethical techniques like instinct, fear, or just letting go the patient. Like, “Oh, he's going to come back when he's motivated.” In the meantime, we don't do anything. That sort of thing, so obviously with substance abuse disorders, it's a big issue, but I would say in psychiatry, it's everywhere. We're promoting lifestyle changes, adherence to treatment. All these are not that well followed with patients with the usual prescriptive methods.

Florence Chanut:

So, I heard about a team that were using Motivational Interviewing, which was absolutely unknown in Quebec, even in addiction treatment facilities, because I mean, I guess everyone knows that in Quebec, the main language is French, which already is a language barrier to have sometimes some novelty in psychotherapy or other things like that. And Motivational Interviewing was first invented by English speakers. So I guess that I'd explained there was a bit of a delay in knowing about Motivational Interviewing and I was extremely lucky because my fellowship was, I guess, one of the best years of my life.

Florence Chanut:

I was with Maurice Dongier a renowned psychiatrist and scientist in alcohol research also psychoanalyst mainly. He discovered Motivational Interviewing like he was almost retired and he got so enthusiastic about, and I was his first student. So I had really a privileged relationship with Maurice Dongier, for the entire year and a half of my fellowship. And we were studying Motivational Interviewing efficacy and especially with driving while intoxicated, the patient and those who didn't respond to the usual remediation measures.

Florence Chanut:

So really the hardcore recidivists, those people think that nothing can change them and especially not a 20 to 30-minute intervention once. So we were studying that and also I had another mentor, Thomas Gordon Brown, the head of the Addiction Research Program at the Douglas Hospital McGill University, which is the first one who really implemented Motivational Interviewing in Quebec. So I had that great experience, but I was already hired by the hospital. In fact, this is the hospital where I'm still working Hospital, Hôpital en santé mentale Albert-Prévost to treat personality disorder patients.

Florence Chanut:

So, I was an addiction psychiatrist, but working with the future of working with personality disorder patients, that's what I did there all along. In many hospitals, a few hospitals, a few settings I also put together integrated treatment outpatient and inpatient treatment program for concurrent disorders. I think in United States, you call them dual disorders. And I'm trying to do that as well for personality disorder back at the hospital at Hôpital en santé mentale Albert-Prévost and we also studied with Teresa Moyers. There was the release of the MITI manual.

Florence Chanut:

In fact, we had a copy before everyone else and to try to make a study of the validity of that scale. So that was a very nice journey that I would say totally changed my identity and the way I relate with patients. And I mean, every patient, because I'm also part-time working with other type of clientele in psychiatry, like psychotic disorders and mood disorders, but they all have in common that these patients that I see, they have addictive disorders as well, but I can see patients with personality disorders without an addiction disorder.

Florence Chanut:

And MI has been the most versatile and powerful skill and tool in my toolbox for my career. I really don't know how my colleagues who don't have this skill are not all in burnout, dealing with very complex problems, persons who are in need of a lot of care. We don't always have all we would like to have to offer them. And also we don't always know how we best behave with them.

Florence Chanut:

I guess it's the same experience for a lot of people who adopted Motivational Interviewing as part of their practice is there's sometimes a nice fit with our personality, like our values that when we value autonomy and the collaboration with the patient, I think that my work with personality disorders also prepared me a little bit for Motivational Interviewing in a way, these are common philosophy of treatment where the patient is really a partner, an equal partner in expertise, and that we are not going to do things to them they don't want to do.

Glenn Hinds:

When you were at the earlier part of your journey when you were studying and when you were just about to go into practice, that you were already noticing a discrepancy within yourself about how people were being treated and the services that you were involved with and addictions and it seems like it was very fortuitous that you found yourself in the company of two very enthusiastic leaders who themselves were just discovering Motivational Interviewing and you became part of that circle.

Glenn Hinds:

Where the three of you would often really explore this thing called Motivational Interviewing and it immediately began to crystallize for you that, there was something in this, not just for addictions work, but really quite significantly in the new path that you were following, which was the support and treatment of people with personality disorders. And I wonder if you could maybe just give us some insight into what personality disorder is, and then we can explore more specific uses of Motivational Interviewing in the treatment of.

Florence Chanut:

I think it's particularly very relevant because that's a special place also in psychiatry or in psychiatric manuals, the personality disorders. First of all, what is a personality disorder? Like a personality is it's a general set of characteristics, how we behave and how we think

and how we also react emotionally to the world around us and we tend to have some sets, some patterns, like everyone has, we all have a personality, and it comes with strengths and it comes with areas where it's a little bit more difficult.

Florence Chanut:

It reaches the level of a disorder when really it impairs our functioning, or it brings you a lot of suffering and suffering typically with personality disorders it's not always the patient who is suffering the most. Sometimes it's the significant others who are relating to that person who might be suffering as well. Borderline Personality Disorder, the main characteristic it's instability.

Florence Chanut:

So, it's instability in behaviors, in mood or emotions, in thoughts and in relationships. So, it's a pattern of being quite intense and then unstable in all these four domains. So that's pretty much the definition, I would say have Borderline Personality Disorder, but then different theory posits certain importance more on this or that aspect, but this is the general definition we agree on.

Sebastian Kaplan:

Right, and whether it's personalities broadly speaking, or even with the topic that we'll be discussing today, which is Borderline Personality Disorder, there's a lot more depth we can go into about the defining features and characteristics and things of that nature. So if any of our audience members are unfamiliar with these terms, just know that we don't have the time to go into them in such rich detail, and just to do some learning on your own to discover that.

Sebastian Kaplan:

So, going back to your early story, one of the things that struck me was your comment about MI, and what has sort of puzzled you about how your colleagues who don't practice Motivational Interviewing and how they're not burned out. I think it's a useful connection point to some of the qualities of people who are struggling with Borderline Personality Disorder, right? Because that's certainly quite a risk factor I suppose, for providers who are working often with people who are struggling in these areas, maybe you can talk a little bit about that?

Florence Chanut:

It's often clientele that is feared and even avoided by therapists or counselors in general, maybe it's because of the intensity of the emotional experience. And one particular aspect of Borderline Personality Disorder is that they have trouble controlling anger. Even sometimes the anger is directed towards the therapist as well, so they might be a little bit frightening. I would say also that one thing that might be difficult in trying to help these patients is that if we are in a helping profession it's because we want to help. We want to be useful to the patient, and we tend to have a lot of things that we think are good to offer.

Florence Chanut:

So, we really want to fix problems and with Borderline Personality Disorder, I would say everyone has that psychological reactants, when somebody wants to tell you to do something, but my impression as a therapist is that with Borderline Personality Disorder, this psychological reactance is more obvious. It's maybe faster to manifest itself in the relationship and it might be more intense. So, I think they are in fact, the best teachers of Motivational Interviewing ever because you have the immediate feedback on what you're doing, if it's good, or if it's bad, but it's not a normal psychology, they're going to react exactly as I would react, but just maybe more intensely and maybe faster.

Glenn Hinds:

Well, it's useful for us to understand them as people who may come into contact with individuals with Borderline Personality Disorder, or even just to help people understand what it is that people experience. And when they have a diagnosis of Borderline Personality Disorder, it's not that there's something uniquely different about them in the sense that what you're saying is the reactions they are having are normal human reactions. It's just the presentation that's different.

Glenn Hinds:

And it sounds like in some ways that one of the challenges for us as care providers is to more fully understand the condition the client is experiencing and that their reactions to us is feedback to their experience of us and that is so important for any practitioner, but particularly for us when we're exploring Motivational Interviewing given that our task is to understand this client, our task is to engage and to support the client through their own journey. And that instinct that you're describing to try and fix, we refer to as the righting reflex that because we want to be helpful, we think we should just provide answers, but it's exaggerated.

Glenn Hinds:

The client's response to that is exaggerated because of the personality disorder. And then it turns out in some ways that without fully understanding that, that, that might explain why there are practitioners who do not look forward to meeting a client of this type. I suppose they're the boundaries of the relationship are very different from inverted commas, ‘normal’ psychiatric conditions, or addiction presentations. A normal person with an addiction and we can relate to the person what this is, is the person that we're meeting their presentation is itself different because of the condition. And the challenge for us as practitioners is to align ourselves with that.

Glenn Hinds:

And it sounds like we often use the metaphor of dancing here. It sounds like it's recognizing this is a different dance. When you work with someone who has a Borderline Personality Disorder, it's a completely different dance than you're doing with someone else. And there's work for you as a practitioner. And it sounds like for you, when you learned Motivational Interviewing it helped you dance much more fluidly and in a way that allowed you to do what you wanted to do, which was to be helpful, but in a way that the client and patient seemed to respond to.

Florence Chanut:

Absolutely, I would say the dance with Borderline Personality Disorder is much more like the dance you would have with anybody in your life, your normal life and not with a psychiatric patient. So that's the big difference that you treating the other as really a fully capable person to take decisions and their choices. Even though sometimes it doesn't sound like it's the best option available, but to really respect fully their autonomy in that. Because also, I would say very often Borderline Personality Disorder patients, they tend to have very low self-esteem and very low self-efficacy feeling so that they're going to make us believe that they're incapable of managing their lives.

Florence Chanut:

And if we think we believe this and we forget about their potential and their capacities, that's where we get in trouble and we can be harmful to the patients. I think that's why also, because they let us feel powerless sometimes. So, we really feel that urge that you named this righting reflex. I totally agree with that. We feel that urge to fix them because they look like they're really a mess and I am here. I want to save them. And Motivational Interviewing offers a much more comfortable way of being with them.

Florence Chanut:

We are a guide if they want a guide, maybe they don't even want a guide when they're meeting you that day. Maybe they just want to talk about this and that, and they don't want anything else. Maybe you can help them make some changes if they want to make some, but you really have to fully respect their autonomy and also believe in their potential. So maybe to go back to the definition of Borderline Personality Disorder, when I present this to the patient and oftentimes it's with their family or a significant other with them in the meeting, we also talk about the other side of this.

Florence Chanut:

The one that is not in manuals, the other side of Borderline Personality Disorder, because all personalities, unlike schizophrenia or bipolar disorder, we all have two sides. We have strengths and we have things that are more difficult. So the person who is perfectionistic is often doing a great job, they're detailed, it's perfect, but slow. So, we have the two sides and with BPD, it tends to be creativity. They can think out of the box.

Florence Chanut:

A lot of them have a lot of energy, much more than me, which can get them in trouble. But if they harness that energy, they can do great things. There's a lot of very high functioning people with BPD. And one of the most famous one is Linehan, Marsha Linehan which is a known researcher on Borderline Personality Disorder. They can be very caring, very generous, altruistic because they have this sensitivity that is very like at skin level.

Florence Chanut:

But if they can give that back to other, when the suffering they have, they suffered so that they can be very generous and they tend to be also very involved in social justice, that

sort of thing. So I also present this other side to them and I think it fits with MI too, because we want to work with the strengths and we want to put the light on them and we're not there to fix them at all. We just want them to be more aware that they have these strengths and use them more.

Sebastian Kaplan:

The capacity you have to view patients with this condition from the standpoint of their strengths is so evident in these early moments of our conversation today. You've described them as the best possible teacher of Motivational Interviewing. You made sure that you view them as just people like anybody else, as opposed to a psychiatric patient. And even just now all this lengthy list of strengths that you've witnessed in people with this condition that you are sure to include in any conversation you're having with these patients and their families just really speaks to, I imagine a really intentional effort on your part to keep those strengths front and center, which for those who have been listening to our podcasts, or maybe have been learning about MI separate from us, you can imagine is quite consistent with the Motivational Interviewing spirit. Maybe you can speak a little bit to the spirit of MI and how you feel like it's guided your work this far.

Florence Chanut:

You're totally right, Sebastian. I think that acceptance is a one key element of Motivational Interviewing spirit. And to accept that a BPD patient is a BPD patient, they have these characteristics, and that includes not taking it personal. If they're reacting very rapidly to what you said of course, in a way it's personal because you triggered that reaction, but it's not personal because they are typically reacting this way as well. So it's not like you can exclude yourself of the relationship, but still the spirit of accepting that they are who they are.

Florence Chanut:

Like I had a mentor on personality disorders say that we don't expect a cat to do something else than meow. We don't expect a BPD patient to be just calm and not do what a BPD characteristic would lead them to do. So you have to accept that and also accept that they're doing the best they can do right now and we're here to help them get the best of them, which is also the vocation component of the spirit to believe in their potential and that we are not essential. We're not essential for them to get better. They can do better.

Florence Chanut:

And that has been proven time and again, in longitudinal studies that the natural course of BPD is continuous remission. So when we have this in mind, it's also, I'm seeing it because when we are in front of an individual that is very in distress and disturbed at that moment, we tend to forget that we're not essential and they have all that they need to get better, but maybe we can help to facilitate this and make it easier or faster. That's how I see my own role. Also, again, for the vocation part of Motivational Interviewing, just the fact that somebody would clarify his values. What do they want in life, what is important

to them and help them get there, I think it's essential, especially with this type of clients, because they are from one crisis to the other.

Florence Chanut:

And they're always in the short term and they forget about the long-term perspective and just to evoke that, help them evoke that and think about it. That can be, I think, therapeutic in itself. I think that what I said earlier also speak about the collaboration spirit. Like we are two equals with two different expertise and if we can help as a guide, then that's great. And I think it's more respectful, it's more empowering of the patients, that type of a relationship, and obviously compassion to really believe that they're suffering.

Florence Chanut:

I've seen some colleagues that I think it's a defensive reaction at some point, they think that they're manipulative, they're not that suffering because when they see them, it seems like they're in the deepest depression that evening and the next day they're singing and they're all well, but it's the nature of the disorder it's rapidly changing, but it doesn't mean that when they are suffering, it's less suffering. So the compassion helps to relate to that and try to be helpful.

Glenn Hinds:

And what strikes me is just how sophisticated the practitioner has to be to have this awareness and to be able to navigate the relationship with an individual who's presenting with Borderline Personality Disorder because of the intensity of the client's experience and the difference in what they're doing. And just the humility in which you describe your understanding and the space that I imagine that must create for an individual who, because of their different presentation, their experience of the world probably is quite confrontative, and they become accustomed to being confronted from a very early age.

Glenn Hinds:

And then they come across a practitioner like you, who is interested, curious, and affirming, and very significantly not taken their behavior personally, and remaining curious with their experience. And as you said at the beginning, being willing to learn about your practice from their experience of you treating them and being willing to make adaptations so that their experience improves because that's what you're driven by, a desire to be helpful.

Glenn Hinds:

And if there is something that you can do to improve that, you're willing to do that for and with them. Maybe just describe some of your own experiences of working with people with Borderline Personality Disorder and what they describe or what it is you notice when they're with you that just confirms that MI is the way forward for you as a practitioner to support the people you want to help.

Florence Chanut:

First of all, I noticed that while I've been working with BPD patients with, or without addictive disorders for 15 years and a little bit more now, I have very, very, very few complaints. I had total of three complaints but one was not a BPD patient. He was a psychotic patient and the two others, the complaint didn't stick because they were probably made under the use of a substance, but it was not intelligible enough that we could make a sense of it. But I would say even if they were valid, the two complaints and I'm dealing with hundreds of individuals a year, more than 15 years, and we know that these patients, they make more complaints in general, they are experts to really see everything that is not right in the system and all our failures.

Florence Chanut:

They're very failures detectors and our system is certainly not failure proof, not at all. So I think that the working alliance I can make with these patients has proven me that MI is certainly very helpful. And also, I mean, I don't have doors, they are slamming doors of my office, if I'm not the right person to help them at the moment we leave in good terms in general. It's really extremely exceptional that I have a patient that is leaving the hospital in a way that is really unsatisfied and really angry.

Florence Chanut:

So just the emotion regulation that is better in the interview with them. I think that it relates to the powerful use of the skills in MI that can be very, very helpful. And also, I think we discussed earlier in the previous conversation about the fear that maybe sometimes this individual can be very suicidal or dangerous and really, I don't know. Using MI I cannot compare exactly what we would do without it, but I would say it's not more than once or twice a year that we have to bring a patient to the emergency room after an interview. And usually we do it ...

Florence Chanut:

I always do it in agreement with the patient. I don't have to force them, we agree that in the moment they need more care, but that's a very rare occurrence once or twice a year. I feel like we have a very respectful relationship that suits me and I think they like it too in general. So these are some clues and also what is really helpful I think with MI is that we can explore, safely explore some very difficult behaviors that can be scary, like self-harm for instance.

Florence Chanut:

I did Motivational Interviews for self-harm and I have one patient in particular in mind, she was even referred from another territory because their psychiatrist was just out of ideas to help her. She was using self-harm so much, like many times a day. Like she was anaemic to a point where she was not even white, she was green. And it was so automatic, such a reflex that she was not even aware of an emotion or a thought that would trigger the behavior. And so I tried with the Motivational Interviewing spirit and techniques to explore that behavior, and it led to very rich conversation about what was important to her in the end. And she was not afraid of dying.

Florence Chanut:

She was not afraid of having a complication, but she wanted to be more present for her children. She wanted to have more energy to play with them. And she felt like this behavior was not letting her do that. And I don't think that healed her completely, but it was certainly the start to change. It was the start of the path to improve and get better. And it was not because she wanted to be healthy, often in the healthcare profession, we think of health as a very high value and that our patients should have this high value and Motivational Interviewing helps us be more open to other values. The need to be the model for change for our patients.

Sebastian Kaplan:

We keep hearing examples of how you see these patients. I just have to refer back. You described them as experts at detecting failures. That's quite a reframe from how you might hear them as being demanding or complaining, but just another example of a creative reframe on your part, interested in shifting a bit towards some of the specific skills. And actually you sort of beat me to it with this example of this woman. And you can imagine how many practitioners might get really caught in this web of self-harm and in particular, this really extreme presentation apparently and amidst that you had the wherewithal.

Sebastian Kaplan:

And maybe it's not too much of a leap to say the courage to step back a bit from that alarming behavior, perhaps life-threatening behavior to explore her values. That seems like one example of a shift that could … Not that you're ignoring your self-harm behavior or that you would just say, “Well, we can't do anything about that. So you might as well go to somewhere, something else.” It's sort of shifting your focus to maybe approach it from a different perspective. Since clearly you're not the first person to explore this particular behavior with this person. So that's one thing and if you wanted to say more about that, that'd be great.

Sebastian Kaplan:

I also would be curious as to your thoughts on what seemed to be almost like a special set of rules that practitioners have for when they're working with patients with BPD, right? There's the expectation that your boundaries have to be particularly from, and perhaps even more distant for fear that you might trigger something or get too close. I've certainly heard my colleagues describe it in many ways like that.

Sebastian Kaplan:

And then does it pose a bit of a challenge with regards to MI because we are very much about developing empathic supportive relationships through the use of skills, like an affirmation, for instance, or obviously the steady use of reflective listening to be more specific about my questions. I guess there's a broader question about other skills that you find helpful. And maybe if you could speak a bit to these rules that practitioners have and how MI fits or perhaps doesn't fit. Maybe there's an adjustment that you make to some of the MI skills that you employ.

Florence Chanut:

Well, maybe it's because I was basically not that sophisticated at BPD. I described that I came to BPD clinical work with an addiction background that I am not that bound to these rules, but I had a good mentor that explained to me that boundaries are basically your own limits as a person, as a practitioner. And it's going to change probably from one person to the other. And it's certainly for me has evolved with time I think I'm much more comfortable with not as strict rules now than I used to be when I began. So I needed these more strict rules, I guess at the beginning to give me safety, is to be comfortable enough as a therapist so that we can work at our full potential.

Florence Chanut:

I have limits like if I'm really too afraid of the safety of a patient or of close relatives around this patient, then I won't do a good job. So I need to respect that these are very rare circumstances. It is to that point, like when you have a good working alliance with a patient, you can be quite confident that you're going to have the information you need to make a decision, an informed decision about what is needed. If there's more security or safety measures that need to be put in place. But I always say that in trainings or with my psychiatric residents in rotations that you have to respect your own limits.

Florence Chanut:

And then if you need to have a colleague to help you with that, have the great opportunity to work in a team. So that is very useful for that type of clientele, because it's nice to have a room to talk about some problems and think it out loud so that you're not yourself in a crisis mode with the patient. It can be a little bit contagious, but if you have the conversation before with another member of the team about this patient, you can have options in your head already, then you're less destabilized and you can be more calm and react more normally with the patient. I don't believe in these very strict rules.

Florence Chanut:

The science has shown that any kind of structured treatment plan would probably be helpful. The structure can depend on the patient, can depend on the clinic. Obviously my work setting sets some opportunities and limitations by itself, and I'm quite transparent with the patient about that from the beginning, they may need something. It doesn't mean that I have the possibility to give it to them. And when we say it and we don't let them think that we have, or we can, or we refuse them because they are them or it's not special to them, then they can really well understand that and don't insist.

Florence Chanut:

But I think that sometimes we're afraid of their reaction. We make them believe things are not, we keep secrets in a way, and that doesn't lead to a good working alliance in the end. So, boundaries, of course, you need to respect yourself. I'm not available 24/7. I need to have my self-care too. I need to have my life to be available, but I think it's true for any kind of patient you see, it's just a good therapist hygiene, I guess, but as for the skills we had this previous conversation, when I said that, I don't think that there's any adaptation necessary to MI with this clientele and I didn't see that.

Florence Chanut:

I know that I heard that therapists, they think that “Oh, they don't really answer well to affirmations. So they don't really like complex affection, avoid that with the BPD patients.” I would say the total opposites, these are very, very, very helpful skills, but I do agree that you need probably a higher level of mastery of these skills to be comfortable in using them with BPD patients. Since what I mentioned of being more intense in their reaction, maybe faster, I would say these three areas of caution with the skills that you need to really be good in doing reflection or affirmation.

Florence Chanut:

The one that I see most frequently is to unintentionally minimize the intensity of their experience and validation, which is like share their inner experience with somebody that make them feel like it's inappropriate or it's not something they should have. They should not have reacted that way. I think that as therapists we don't do that as openly, but we tend to do it a little bit. And that's, I would say it's in the line of the righting reflex again since they're dramatic in their presentation. Sometimes we think that it's our job to de dramatize the situation to soften it a little bit, or you should not ask them that bad, or maybe it's going to make them feel more in distress if I reflected the way that they said it to me, and my experience is the total opposite.

Florence Chanut:

If we don't match the intensity of what they're saying, of what is their experience, they're going to just try to make you understand that “No, you didn't get it.” Let's say a patient says, “Last night when she left me alone, I was desperate.” If you answer by, “You are sad,” sad, and desperate, really not the same level of intensity, or even if she say very sad, it's doesn't match, but you have to say something like at that moment, you couldn't imagine how you would do without that person. So you need to match. But I intentionally put some time reference points in my reflection, I guess it's to preserve hope.

Florence Chanut:

And it's also, that the emotion was very intense, but it was not forever. But when the emotion is really intense, it's a new human, I think behavior we tend to think that it's going to go on forever. It's a way to put some limits to the experience like it's not forever, but it was very intense. I agree with that. That is one area of caution. Be very, very cautious that not to minimize the intensity of their suffering. The only exception I would say that where I intentionally minimize or make, it's not really minimize it's to put the distance between what they're saying and what I choose to reflect is when it comes to their sense of confidence, self-efficacy, self-esteem everything that is around that area I treat it like crystal glass.

Florence Chanut:

I use terms, and that's a bit funny because I'm in my second language talking about skillful use of language, but I don't feel that skillful right now, but let's say I try. Okay. So if the patient says something like, “The other day after this or that happened, I was so outraged. I thought I was about to hurt him. I almost lost it.” You could use a reflection that is, “Okay.

You almost lost control." That is technically okay. It's a reflection and it is a part of what the patient has said. We put the spotlight on what went wrong and the patient they're coming with a lot of examples of that.

Florence Chanut:

They're not coming with all the things that they did well, they come with the things they feel bad about. So we can put unintentionally a lot of light on things that are not so self-efficient. So a better way would be to change that and say something like, "The anger was so intense that you felt like you would lose control," or that the same thing with the feeling, "You felt anger very much." Instead of, "I was depressed. I was … You felt depressed."

Florence Chanut:

You make a little distance, you put it in the distance, and you can even go beyond and use affirmation. Like, MI has this marvellous way of putting the emphasis on the good and the strengths of the person and we really want to have that frame with the patient. So that same situation we could even go and say at that person, that that anger was so, so strong, so, so intense and yet they didn't lose control.

Glenn Hinds:

There's just so much richness in what you're saying, I'm just conscious of how significant I imagine this will be for a lot of people who are listening and I really appreciate the insights that you're offering and what strikes me is just how authentic the space that you are and creating for people, how authentic you are being when you're being with people and that you have experimented over the years with the way you practice to the point where you're able to create a space where people on a spectrum and thinking about our podcast with David Prescott, who talked about working with sexual predators.

Glenn Hinds:

And with Rory Allott, who talked about his work with people with a diagnosis of psychosis, and if we think of the spectrum that they are individuals who are right at the end of the spectrum. And I guess that this is also where you enabled another validity to create a space where people can come and be themselves with you being yourself so that you together then can be curious, "What is it you want with your life? This is part of who you are. You currently have a diagnosis of Borderline Personality Disorder. Now what? What do you want to do about that? What would be helpful for you? How do you want to maneuver and gauge your way through life?"

Glenn Hinds:

Knowing that there are people out there who are going to react and have been reacting the way they are, but what would be helpful for you in the time that we have together and just that willingness to go to the heights of their emotional state and be with them. And I guess that from being with you, that makes sense would be that when I am being very heightened in my experience of myself, that my experience of being that with you is that

if you are calm, you are centered, you are paying attention that you're not being pulled out of shape by my behavior.

Glenn Hinds:

And that must be very reassuring for the individual that they're not having to protect you from themselves, which is an awful lot of what they're probably experiencing, and other people tell them, “Don't be sharing, don't be going on like that. You've got to be different for me to give you the attention,” and you're going, “You've got my attention.” And I'm just curious what this means for you. And I guess at that, a lovely invitation for people who are listening, who maybe moving under this word or are currently working on mental health that there's a journey that you have been on.

Glenn Hinds:

And it is a journey that we're all on as practitioners to become able to create a space where another human being can feel safe with us and that's work that we have to do for ourselves. And it sounds like you've been helped to get to the place where you are this capable and strong with the support of a number of mentors along the way. What would you be suggesting that people who are interested or are already working in this field, what is it they need to be looking for, for people to support them to develop to the point where you are from other people from their mentors or from supervisors?

Florence Chanut:

I guess that I had mentors who were very much into Motivational Interviewing themselves, and thinking about Tom Brown and in particular, he was really being MI and I always liked to Bill Miller saying about what's the difference between learning and being MI is 10 years. I think it requires anything else than curiosity, also humility, like, just to doubt, maybe it's me. I'm a person with lots of doubts. So, I'm always trying to see if I can do things a little better, how I can be more useful, but I have to say also to work in a team is probably very helpful to stay safe as a therapist.

Florence Chanut:

Working with the severe end spectrum of that clientele so that if I'm in trouble, I can always knock on the door of somebody. So I guess not being isolated as a practitioner is important when you're treating that kind of patient, there's a community out there, Motivational Interviewing community that is very welcoming and really very affirming too, like you are with me today. So I thank you for that.

Sebastian Kaplan

I'm conscious of the time. And we would often start to wind down at this point however, I might suggest or hope that it's okay if we extend this a bit more. One thing I want to do is just summarize some of the skills that you've been mentioning throughout and which I think have been really important to hear. So one was the idea of exploring values as a way of responding to places where you might get stuck in treatment, or if the person is presenting with sort of recurrent problems that they're having trouble getting out of, to

kind of shift focus a bit to, “What do they find important in their life, or what are some of the drivers in their life?”

Sebastian Kaplan

That, that could be a way to get back to that original topic, the idea of reflections, and you really emphasize the importance of matching the intensity of the person's experience, but also finding a way to provide containment to that, which is a really wonderful nuance to reflection that I haven't really heard many people describe, it both honors their experience, and genuinely provides some containment around it. Like you said, it's not something that lasts forever. It did last forever. It had a beginning and an end and it was, yes, it was very intense.

Sebastian Kaplan

And that's something that you reflect back. You described being rather transparent and straightforward about the limits of yourself as a person and of the clinic and the services that you provide. And you do that in a very matter of fact way upfront. And that that's how it is for everyone that goes into the clinic. And it's nothing that needs to be sprung on them. If they break a rule or that it's unique to them, it's just, it's just how you work. And you find that helpful.

Sebastian Kaplan

Lastly, the use of an affirmation is not something that you shy away from quite the contrary, and maybe similarly to a reflection, you try very hard to honor the distress that they're experiencing. And if you find a way, or if it seems apparent that you're noticing that they've done something helpful for themselves, or if they've been trying to implement a particular skill that they've been working on, despite a difficulty or problem, or where the distress that they're experiencing in session, you name it for them. And that's not something that you really shy away from.

Sebastian Kaplan

So those are, and maybe there were some others, but those seem to be the ones that really stood out for me. What I'd like to explore is the notion of stigma for people who have this diagnosis and just hearing what your thoughts are about that. And I know at least in the work that I do in terms of working with psychiatry residents, I feel like very often there's a forgetfulness or a lack of appreciation about where this presentation and this sort of way of making life more tolerable where does that come from?

Sebastian Kaplan

Oftentimes experiences of childhood abuse, which we know based on research, but because the work can be quite challenging in the moment, it's really easy to lose sight of that or to lose sight of the broader context in which the person has come forward with. And then I guess maybe another way of thinking about it is these challenging behaviors, so to speak that there's some need that the person is trying to meet, and there's a function to that. And that's also something that may not be readily apparent in the heat of the moment. So I don't know how you see those sort of that perspective taking on the part of

the provider, if it might help with reducing stigma when working with these patients, but happy to hear your thoughts about it.

Florence Chanut:

It's very nice that you point out on this issue because there's been some articles in the latest years that have pointed out, that we tend to stigmatize these patients, this group of patients, even more than all other diagnosis in our healthcare system. When I read that it was already there, but it made it just more obvious. When I'm a consultant for concurrent disorders on the inpatient wards, and there's a patient with more challenging behaviors or is less cooperative that tag of, “Oh, it's a personality disorder.” And then you see that the clinician's eyes roll up.

Florence Chanut:

I have to say that sometimes also that the tag is not right. There's a lot of other causes to challenging behaviors. It can be a lot of other things and the personality disorder. But I would say that the most efficient way, at least for me to be compassionate, because I think that the answer to stigma is compassion. And also, I have compassion for the therapists as well. I think that if you don't have the training that I had, you don't have Motivational Interviewing as a part of your tools, or if you didn't have the chance of working in a team or having the mentors I had or whatever else, then it can be quite natural to feel frustrated or powerless with these patients.

Florence Chanut:

So, I have compassion for the therapist too, but to have compassion to these patients, I think the best antidote is to read their longitudinal story, their personal story. There's never smoke without fire, there's always causes. We know now that there's a bit of a predisposition that biologically speaking, being more reactive emotionally and all that to have personality disorder and also, you also need to have the difficult life events, the trauma experiences to develop the BPD.

Florence Chanut:

When facing very difficult or challenging situation, clinical situation when I have sometimes to remind myself of that, the story behind it, that helps me to first not take it as personal and also just see them as survivors. They survived the very adverse life situations, and that shows up. And then that shows up and in fact, a lot by mistrust, basic mistrust, that's also another way why Motivational Interviewing, I feel that it's so helpful because we put a lot of effort in engaging and build a trusting relationship with the person.

Florence Chanut:

And then yeah, I would say about stigma it's the more we know about the disorder, how to deal with it then the less we have to feel this way about it. And also the other antidote are the studies of the spontaneous remission and prognosis that I think it's very encouraging. We feel as practitioner, we may feel less it's on our shoulder to do all the job that we need to change them. So I think we can have a lighter approach, more calm and more modest.

Glenn Hinds:

And I think that's a beautiful idea or thought to bring the podcast close to an end, is just that concept of the way you can respond to witnessing someone else's stigma is to meet it with compassion. Equally important and just as beautiful was when you witness someone manifest stigma towards someone else one of the ways to support them is with compassion. It's the compassion that is the healing agent and multiple individuals can experience something different because something new is happening in the conversation.

Glenn Hinds:

There isn't a reaction from you. There is a response with kindness, with love, with understanding. This makes sense, some level where you're behaving like this makes sense whether you are the patient or you are the practitioner, your response to this situation makes perfect sense if I knew your life. And for that reason, I honor your journey and I'm not going to make you feel guilty about how you're doing it, but I'm going to be curious about why it's happening for you and explore what was happening and why you might choose to do it slightly differently.

Glenn Hinds:

So that's a beautiful invitation for all of us. Thank you, Florence. And at this stage we normally ask our guests, if there is anything currently going on for you that's catching your attention, whether that's Motivational Interviewing oriented or not. So, I'm just wondering, were you paying attention to at the minute?

Florence Chanut:

I'm currently very curious about the compassion approaches and self-compassion too. I think it fits perfectly well with Motivational Interviewing too. I think we all need that and also, I mean, on the news, there's so much about stigma and a lot of suffering and also with the COVID-19 pandemic. I think it has been the time where we want to reflect that a bit more on how we relate to each other and how we relate to ourselves and to do it like I have a softer touch in general. So that's what is catching my attention.

Sebastian Kaplan:

Opportunities to use that compassion that you possess towards yourself and towards others is really quite at the front of mind for you these days. And we also ask our guests as we come to a close, if anyone in the audience had questions for you or would like to contact you, and if you'd be open to that, how might people reach you?

Florence Chanut:

Totally open to that. I will be very welcome. For me the best way to reach me would be through my email address, which is my name Florence.chanut@umontreal.ca. So that's my email, but I also have a Twitter account under my name, a Facebook account under my name. That's probably the best way to reach me.

Sebastian Kaplan:

Glenn, before we say goodbye to Florence, just remind our audience, how people can get in touch with us.

Glenn Hinds:

Of course. So on Facebook, it's Talking To Change. On Twitter it's @ChangeTalking, on Instagram it's Talking To Change Podcast and by email it's podcast@glennhinds.com. And of course, if you're listening, whatever platform you're listening to this episode on, we would really appreciate it as you switch off this episode, just go to the review, leave comment, if there's a star section, give us a couple of stars, we really do appreciate the feedback. And it allows other people who are interested in the podcast to be drawn based on your feedback rather than what it is we present. So, that would be very helpful.

Sebastian Kaplan:

Hopefully more than a couple of stars but of course, if that's the honest review.

Glenn Hinds:

Yes, we search for authenticity.

Sebastian Kaplan:

Well, Florence, thank you so much. This was wonderful. So many helpful pointers, as far as your approach, your mindset, some of the specific skills, it's been a really wonderful discussion today. So thank you so much for joining us.

Florence Chanut:

Thank you to you, and thanks for bearing with my English too. I hope I was understandable.

Glenn Hinds:

Yeah. We both have to nod to your courage and coming on and recognizing English isn't your first language and so thank you for that. And we hope that we were supportive for you and because we both really valued what it was you contributed today. And I have no doubt that there are many people in the audience who will have come away with a much broader and useful understanding of what it is to be working with someone with a Borderline Personality Disorder. And as a consequence that we can hope that there are individuals out there who will get better care as a consequence of having had a chance to listen to your experience and sharing your wisdom. So thank you for that.

Florence Chanut:

My pleasure.

Sebastian Kaplan:

Bye-bye Florence and Glenn, until next time.

Glenn Hinds:

Indeed.