Rethink Group of the Year 2023 Issue Thirty – Winter 2025/2026

Borderline Derbyshire

Newsletter of the

Derbyshire Borderline Personality Disorder

Support Group

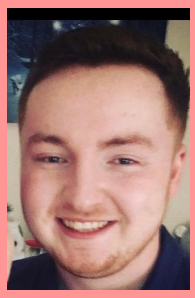
For anyone affected by
Borderline Personality Disorder (BPD)
also known as
Emotionally Unstable Personality Disorder (EUPD)

For those in Derbyshire and beyond!

Est. 2017

Who we are...



Sue | John | Jodie | Ryan

We all have a connection with BPD

What we do...

Our aim is simple…we want everyone who is affected by BPD to have a safe space in which they can come together to relax, chat, swop stories and discuss coping skills, in a non-judgemental way

An official diagnosis is not necessary

The main point of contact is through our WhatsApp groups

Members are encouraged to arrange their own zoom and face-to-face meetings

You do not have to live in Derbyshire to join our support group

SUPPORT Group

News

Internal Family Systems (IFS)

A different kind of therapy

IFS is frequently used as an evidence-based psychotherapy, helping people heal by accessing and healing their protective and wounded inner parts.

IFS , also known as *Parts Therapy*, is becoming a more and more accepted and scientifically validated form of therapy, particularly regarding trauma therapy.

In this issue we have included extensive details of this comparatively little-known therapy (pages 7-14).

You can find more information, including negative critiques of the therapy, online.

We would like to wish all our members a very merry Christmas and a Happy New Year!

Sue xx

Vicky was a co-founder of the group and my soulmate of 36 years. Sadly, she passed away just before Christmas 2021.

Sleep tight darling!

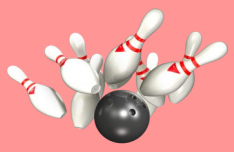
Sue xxx

What we offer...

Occasional Zoom Meetings (arranged by members)

Quarterly Newsletters

Occasional Meet-Ups (arranged by the members)



WhatsApp groups

BPD chat

Autism & BPD

Women with BPD

Parent/Carer/Family/Friend

Positivity Group

Borderline of Nature

Crisis Card

Website:

derbyshireborderlinepersonalitydisordersupportgroup.com

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All BPD
WhatsApp Groups

We welcome and support
all new members regardless of gender, sexuality, age, race, religion or disability

We maintain a non-judgemental environment where members are open-minded and encouraging

We recognise that every member is important and will be treated with respect

IMPORTANT
If you post something on subjects that may be upsetting to others (self-harm; suicidal thoughts; bereavement; abuse; criminal behaviour, etc) please start with TRIGGER WARNING or TW and then leave a space underneath before you start writing.

Thank You!

De-pathologizing The Borderline Client

by Richard Schwartz

Inevitably, given their history of trauma, many borderline clients will trigger their therapists from time to time. But forgoing the urge to blame these clients and taking responsibility for what's happening inside you can become a turning point in therapy.

I've specialized in treating survivors of severe sexual abuse for many years, which means that many of my clients fit the diagnostic profile of borderline personality disorder. Therapists typically dread these clients since they can be among their most difficult, unpredictable, and unnerving. My clients have often been highly suicidal—some threatening suicide to manipulate me, and others making serious attempts to kill themselves. Many have been prone to self-harm, cutting their arms or torsos and showing me the raw, open wounds. I've known them to binge on alcohol to the point of ruining their health, to drive under the influence, and to show up drunk for sessions. Sometimes they've acted out by stealing and getting caught or exploding into such rage in traffic or on the street that lives were actually in danger.

At times, they've formed a childlike dependence on me, wanting—and sometimes demanding—not only my continual personal reassurance, but also my help in making even small decisions, like whether to get a driver's license. Some have had tantrums when I've left town. Others have wanted regular contact between sessions and asked to know in detail how I felt about them and what my personal life was like. They've continually tried to stretch my boundaries by demanding special treatment—such as free sessions and extra time on the phone to talk about every detail of their lives—or violating my privacy by finding out where I live and dropping by unannounced. When I've set limits on my availability by telling them when or if they could call me at home, some have responded by implying or stating outright that they might cut or kill themselves.

Sometimes I've been idealized—"You're the only person in the world who can help me!" Other times, I've been attacked with head-spinning unpredictability—"You're the most insensitive person I've ever known!" During therapy, some clients have suddenly shifted into behaving as if scared young children had just taken over their bodies; others have erupted in almost murderous rage at seemingly small provocations. Repeatedly, progress in therapy has been followed by self-sabotage or a backlash against me that's made treatment seem like a Sisyphean nightmare.

Early in my career, I'd react to such behaviours as I'd been taught, correct the client's misperceptions about the world or about me, firmly enforce my boundaries by allowing little contact between our weekly sessions and refusing to disclose my own feelings, and make contracts for them to help them refrain from harming themselves or acting out. Not only did this rational, impeccably "professional" approach typically not work, it usually made things worse. My careful, neutral responses seemed to turbocharge client dramas, and I spent large chunks of my life preoccupied with clients who never seemed to get better.

In retrospect, I can see that despite my best intentions, I was subjecting too many of my clients to a form of therapeutic torture. By interpreting some behaviours that scared me as signs of severe pathology and others as forms of manipulation, I often made matters worse. I hardened my heart against these troubled clients, and they sensed it. They felt that I'd abandoned them emotionally, especially during crises, when they most needed a loving presence. My well-intentioned attempts to control their risky behaviours frequently convinced them that I didn't get it, and even that I was dangerous, no different from their coercive perpetrator.

Richard C. Schwartz, is an American systemic family therapist, academic, author, and creator of the Internal Family Systems branch of therapy. He developed his foundational work with IFS in the 1980s after noticing that his clients were made up of many different pieces of "parts" of their "Self."

Continued...

Of course, I'm not alone in having these experiences. Many therapists become detached, defensive, and directive when confronted with the extreme thoughts and behaviours of their borderline clients. It's hard not to have these reactions when you're responsible for protecting someone who seems out of control. Alternatively, some therapists react by trying to be even better caretakers, expanding their boundaries beyond their comfort level until they grow so overwhelmed and resentful that they end up unloading their clients onto someone else.

The Internal Family Systems Perspective

These struggles can result just as much from therapists' reactions to their clients' behaviours as from the clients' intrapsychic extremes. How therapists react is largely determined by their understanding of what's happening. The Internal Family Systems (IFS) approach, a model that I've developed over the past 30 years, offers an alternative to conventional ways of working with borderline clients. It can make the therapist's task less intimidating and discouraging, and more hopeful and rewarding. From the IFS perspective, borderline personality disorder symptoms represent the emergence of different parts, or subpersonalities, of the client. These parts all carry extreme beliefs and emotions—what we call *burdens*—because of the terrible traumas and betrayals the client suffered as a child.

The central task of IFS therapy is to work with these parts in a way that allows the client's undamaged core *self* to emerge and deep emotional healing to take place. If each part—even the most damaged and negative—is given the chance to reveal the origin of its burdens, it can show itself in its original valuable state, before it became so destructive in the client's life.

Suppose that you were sexually molested, repeatedly, as a child by your stepfather and could never tell your mother. As an adult, you'll probably be carrying parts of yourself stuck back in those scenes of abuse, isolation, and shame. Those parts remain young, scared, and desperate, and when they surface in your consciousness, you're pulled back into those dreadful times. This cycle raises the same terrible memories, emotions, and sensations that you swore decades ago never to think about again. I call these parts your *exiles* because you try to keep them banished and locked away, deep inside. However, when not actively hurting, these parts are sensitive, trusting, playful, and imaginative, so suppressing them stifles some of your capacities for love and creativity.

Exiles: the parts that are suppressed

Much of the time, these exiles remain hidden. They're kept buried by protective parts, which use various strategies to prevent you from experiencing them. One strategy is to prevent the exiles from being triggered in the first place. These *protectors* organize your life, so you avoid anyone who reminds you of the stepfather and remain at a safe distance from people in general. They constantly scold you, forcing you to strive for perfection to keep you from being criticized or rejected—which would bring up the feelings of shame, fear, and worthlessness carried by the exiles. Despite these protective efforts, however, not only does the world still manage to trigger your exiles, but the exiles themselves want to break out of their inner jail so that you'll deal with them. Their breakout strategy comes in the form of flashbacks, nightmares, panic attacks, or less overwhelming but still intense and pervasive feelings of anxiety, shame, or desperation.

Protectors: help you to avoid any form of distress

To escape the bad feelings generated by the exile states, other parts of you develop an arsenal of distracting activities, to be used as needed. You feel the urge to get drunk, or you abruptly go numb and find yourself feeling confused and flat. If those efforts don't work, you may be both comforted and terrified by thoughts of suicide. If you qualify for the borderline personality disorder diagnosis, it's likely that you also have two sets of protective parts that specialize in handling relationships: the *recruiters* and the *distrusters*.

Continued...

Recruiters: look for nurturing figures

Suppose your mind were a house with lots of children and no parents. The younger children are badly hurt and needy, and the older ones, overwhelmed with the task of caring for them, have locked them in the basement. Some of these older ones desperately want to find a grown-up to take care of these basement orphans. These are the *recruiters*. They search for likely prospects—therapists, spouses, acquaintances—and make use of your charm to recruit those people into the role of redeemer. However, these recruiter parts share with your exiles a sense that you're basically worthless, that as soon as people see how vile you are, they'll bolt. They believe you have to prove yourself special in some way or manipulate people, so they'll continue to play the redeemer role. The recruiters also believe that caring for your exiles is a full-time job, so they try to invade the life of whomever they target.

Among the older kids in this house of your mind is a faction that tries to protect the basement kids in a different way—by trusting no one and keeping them away from people who might falsely raise their hopes of liberation. These protectors have seen in the past what happens when the exiles attach too strongly to a potential redeemer. The exiles become infatuated with the supposed redeemer, who inevitably lets them down by never helping enough, or even by becoming repulsed by their neediness. The protectors have seen how the redeemer's distaste and rejection devastate the basement children, so these "big brothers" make sure you remain isolated, detached, completely engrossed in work, and emotionally unavailable. They remind you that the redeemers flee because you're truly repulsive—and that if others are allowed to get close enough to see you as you really are, they'll be disgusted, too.

Distrusters: stop you from getting close to someone so that you don't get hurt

Whenever your recruiters override the distrusters and succeed in getting you close to someone, these distrusting protectors watch that person's every move for signs that the person is false and dangerous. They scan everything about your therapist, for instance—from his taste in clothes and office furniture to perceived shifts in his mood or lengths of his vacation. They then use these imperfections as evidence that he doesn't really care or is incompetent, especially if he ever does anything that reminds you of your perpetrator. If your therapist uses a similar phrase or wears a similar shirt, he becomes your stepfather. So, your therapist innocently enters the house of your mind and quickly finds himself caught in the crossfire between these sets of protectors: one set will do almost anything to get him to stay, and the other set will do almost anything to get him kicked out. If the therapist lasts long enough, he'll be subjected to the suffocating needs of your basement children and exposed to the disturbing methods the older children use to keep them contained. A therapist unprepared for this inner war or untrained in approaching these various internal factions will become embroiled in endless battles.

Case study: Pamela

Early in my career, before developing IFS, I began seeing Pamela, an obese, 35-year-old office manager who came to the mental health centre where I worked complaining of depression and compulsive eating. In our first session, she said she thought her dark moods might be related to having been sexually abused by a babysitter when she was 10 years old, but that she also felt alone in life and stuck in a job she hated. She liked that I was young and seemed kind and wondered if she could come in twice a week. I, in turn, looked forward to working with her, appreciating how eager and articulate she was compared with the sullen adolescents who made up much of my caseload. For a number of sessions, I coached her as she debated leaving her job and developed an eating plan. I felt confident that her trust in me was growing, and I was enjoying the work, which seemed to be progressing nicely.

Continued...

Then came the session when she began talking about the abuse. She became frightened and weepy and didn't want to leave my office at the end of the hour. I extended the session until she seemed to recover and could leave. I was bewildered by this shift but understood that we'd hit on an emotional subject. In her next session, Pamela was apologetic and worried that I wouldn't work with her anymore. I reassured her that I thought the last session had been the beginning of something important and that I was committed to helping her. She asked if she could come in three times a week, in part because she was having some suicidal thoughts. I agreed.

This pattern repeated in the following session: she began talking about the abuse, then became mute, started to cry, and seemed increasingly desperate. I tried to be empathically present, trusting my Rogerian instincts.

What Is Person Centered Therapy?

The subsequent session began in the same way, and then someone knocked on my door. Although I ignored the knock and encouraged Pamela to continue, she erupted furiously, "How could you let that happen? What's wrong with you?!" I apologized for forgetting to put the in-session sign up, but she'd have none of it and bolted from the office. I tried futilely to reach her several times that week, grew increasingly panicked as she missed all her appointments, and was about to call the police when she showed up unannounced at my office, repentantly pleading for me to continue seeing her.

I did continue, but no longer with an open heart. Parts of me had felt powerless and frightened during the week she was missing, and other parts resented the way she'd treated me. I should have had the sign up, but her reaction was way over the top, I thought. I began resenting all her requests for more of my time. I'm now certain that the work with Pamela didn't go well in large part because she sensed this shift in me and my feelings about her. There were further suicidal episodes and escalating demands for reassurance and more time. She even began running into me on the street. I suspected she was stalking me—which made my skin crawl. Try as I might to hide it, I'm sure my exasperation and antipathy leaked out at times, making her recruiters more desperate to get me to care and her distrusters more invested in driving me away.

After about two years of working with her in this way, she died suddenly of a heart attack related to her obesity. I'm ashamed to admit that I mostly felt relief. I'd never developed any real awareness of my role in her downward spiral and had been feeling increasingly burdened by this "hopeless borderline."

Advancing Self-Leadership

After many years of learning from clients like Pamela about their inner systems, my style of therapy has changed radically. From that experience with her, I understand why so many therapists retreat to their own inner fortresses, hiding their panic and anger behind a façade of professional detachment. If you don't have a systemic perspective on what's going on, you're faced with what seems like the wildly oscillating expressions of different, often contradictory, personalities.

From the IFS perspective, however, the shifts in demeanour that signal the appearance of different subpersonalities aren't bad news. Far from necessarily being evidence of extreme pathology on the client's part or incompetence on the therapist's part, the emergence of these subpersonalities signals that the client feels safe enough to let them out. In IFS land, things like flashbacks, dissociation, panic attacks, resistance, and transference are the tools used by the different parts and, as such, are useful signposts indicating what needs to happen in therapy.

Continued...

If therapists understand borderline personality disorder in this way, they're more comfortable with jarring shifts, personal attacks, desperate dependence, and apparent regression, as well as controlling and coercive behaviours. Because these behaviours aren't signs of deep pathology, they shouldn't be taken personally. They're part of the territory. The attacks are coming from protective parts whose job it is to make you feel bad and force you to retreat. The regression isn't a crossing of the border into psychosis: it's a sign of progress because the system feels safe enough to release a hurting exile. The manipulation and coercion aren't signs of resistance or character disorder: they're just indications of fear. The self-harm and suicidal symptoms aren't signals of scary pathology: they're attempts to self-soothe.

This perspective can help you remain the "I" in the storm—grounded and compassionate in the face of your clients' extremes. It's like having X-ray vision. You can see the pain that drives the protectors—which helps you avoid overreacting to them. The more accepting and understanding you are of your clients' parts when they emerge, the less your clients will judge or attack themselves or panic when they feel out of control. The better you get at passing the protectors' tests, the more they can relax, allowing your clients' calm, confident, mindful self to separate from the protectors and emerge.

A hallmark of IFS is the belief that beneath the surface of their parts, all clients have an undamaged, healing self. At the beginning of therapy, most borderline clients have no awareness of this inner self, so they feel completely unmoored. In the absence of self-leadership, parts become scared, rigid, and polarized, like the older kids in the parentless house. As the therapist perseveres with his or her calm, steady, compassionate self, clients' parts will relax, and their self will begin to emerge spontaneously. At that point, clients will start to feel different, as if the stormy waves of life are more navigable.

Case study: Colette

I recently began work with a 42-year-old client named Colette, who'd been in and out of several treatment centres for an unresolved eating disorder and diagnosed by the last two centres with borderline personality disorder. Like so many borderline clients, she'd been sexually abused as a child—in her case, by a neighbour. However, her previous treatments had focused mainly on getting her to examine and correct her irrational cognitions around the eating disorder.

She told me she'd heard that I was good at helping people with their traumas. I said I could help her with the parts of her that had been hurt and were stuck in the past. I added that we wouldn't visit those parts until we'd gotten to know them and received their permission to approach those emotions and memories. In subsequent sessions, I helped Colette talk to and reassure several different protectors, including her eating disorder, so they wouldn't be afraid of our contacting her exiles.

Once she got tentative permission to proceed, I encouraged her to focus on the memory of the abuse. She saw herself as a curious 5-year-old girl who'd been lured to the neighbour's house to play with his pet bunnies. Colette became able to witness the ensuing abuse scene with compassion for her younger self. In her mind's eye, she could then enter the scene and bring the girl to safety. Her protectors were relieved to see that this part was no longer so vulnerable and said they were considering taking on new roles. As Colette left that session, she said she felt hopeful for the first time in a while. I was moved by the intensity of the work and grateful for the privilege of being allowed to share in her journey.

In the next session, however, Colette was distant and shut down. She said she had no memory of what we'd done in the previous session and that continuing to work with me wasn't a good idea. She added that she'd come in just to say that this would be our last session. There was no talking her out of it.

Continued...

Despite knowing better, there are still young parts of me that get disappointed by such sudden downturns and others that feel pouty when I work hard to help someone who doesn't appreciate it. So, at that point, one of my own protectors took over, and I said with cool, clinical detachment that I was really sorry to hear this news, but if she was certain, I'd be happy to give her referrals. As we chatted a little longer, I had a chance to notice the reactive part of my own personality that had been triggered. I reminded it through inner dialogue that it didn't have to take over. *I know you think she's ungrateful*, I told my reactive part, *but it's really just her own protective parts that are scared. Just relax a bit. Let me handle this and I'll talk to you after the session.*

As my protective part receded, I sensed returning feelings of empathy and care for Colette and gained a clearer perspective on why she was being so distant. I interrupted our conversation and said, "I owe you an apology. You wanting to stop surprised and disappointed me. I've been feeling really good about the work we've been doing and want to keep going. I get that our last session upset some parts of you that maybe we need to hear from, and I'm totally open to that."

Colette thanked me for my time and said she appreciated my honesty, but she still wanted to stop. Then, during the week, she called to ask if we could meet again. At that next session, she said that my telling her that I wanted to keep going had meant a lot to her and she'd already negotiated with the part that had fired me to give me another chance. I told her I was glad for the second chance, but that I wasn't sure what I'd done to be fired in the first place. She said she wasn't sure either, so I told her to focus on the part that had pink-slipped me and ask it why. When she did, she said the part refused to answer and started swearing at her instead. I had her ask the part if it was willing to talk to me directly. The answer was yes.

Dick Schwartz: *Are you there?*
Colette's Protector, in a harsh voice: *Yes. What do you want?*
DS: *So you're the part that fired me. Is that right?*
CP: *That's right! She doesn't need this bullshit. And you're such an asshole!*
(There's a part of me that reacts reflexively to being called names. I had to ask this part to relax so that I could stay curious.)
DS: *I appreciate your willingness to talk to me. I want to know more about why you think what we've been doing is bullshit or why you don't like me.*
CP: *You're no different than the last two loser therapists. You all get her hopes up and then shit on her.*
(I sensed a part of me wanting to argue with her protector and convince it that I'm different, that I'm safe and won't hurt her. I reminded it that this approach doesn't work.)
DS: *I get that you have no reason to trust me. She's been betrayed by lots of people who told her to trust them, and she's gotten her hopes up and been disappointed lots of times. I also get that you're determined to keep those things from happening again, and you have a lot of power to do that. You're the boss, and we're not going to do anything more with her traumas without your permission.*
CP: *You're an asshole! I know what you're doing right now with this caring therapist bullshit. I see through you, asshole!*
(Now a part of me was saying that this was a pointless and tiresome waste of time and it was sick of being insulted. I asked it to step back.)
DS: *OK. As I said, I don't expect you to trust me until I've proven myself to be trustworthy. I do appreciate that you let her continue to see me even though you have these feelings about me, and I want to check in with you frequently to see how we're doing. Now I'd like to talk to Colette again. Are you there, Colette?*
CP: *Yeah. That was weird! He's always been so mean to me that I never realized that he's trying to help me. While he was talking to you, I could feel his sadness.*

DS: *So how does that make you feel toward him?*
CP: *I feel sorry that he has to act so tough when he's so sad himself.*
DS: *Can you let him know that? See how he reacts?*
CP: (after a pause) *He seems softer. He's not saying anything and just seems sad.*

Continued...

As Colette listened to me talk to her protector, she got a different sense of that part. When I asked how she felt toward it afterward, it was clear that her 'self' was more present. Her voice was calm, and she exhibited a confidence and compassion that had been missing in earlier discussions about this part. She still felt sorry for that protector in the next session, so I had her convey her new compassion to the part through inner dialogue. Initially it reacted with the same kind of contempt for her that it had shown toward me, telling her that she was a worthless fool to trust me. But as I helped her keep her heart open to it, the part disclosed that it liked that she'd finally realized it had been trying to help her.

Later in the therapy, after Colette had unburdened many more exiles, she began with my support to make big changes in her life. She stopped bingeing and purging and left a relationship in which she'd been recreating some of the original abuse patterns. I'd become fond of her and revelled in her growth and in my ability to help her. Then one day, I got a phone message from her that gave me chills. The voice on the message was deep and menacing. "You can't have her. She's mine!" it said, and then hung up. I called back and got no response. Suddenly I felt a knot of panic in my belly similar to the one I'd felt with Pamela. Here was a client who might be in danger, and I couldn't reach her. Fortunately, I had a few days to work with my distress before our next session. I asked a colleague to help me with a part of me related to a time in my early life when I felt powerless to help someone. This work turned out to be revealing and valuable.

"Trigger Warning"

When Colette came to the next session, she looked downtrodden and reported that she was back to square one, bingeing again and attempting to reignite the relationship she'd left. She was having suicidal thoughts for the first time in years. She remembered calling me but couldn't recall what she'd said. Because I'd gotten so excited by her progress, I sensed my heart drop and a familiar inner voice question whether we'd achieved anything at all in our work together. I asked this part to let me stay present. I connected to her and felt the shift toward more spaciousness that comes when my self is more embodied.

I told her to focus on the suicidal impulse and ask the part of her that feared it to step back, allowing her to simply be curious. Then she was able to ask the other part why it wanted her to die. The scary voice from the phone message replied that its job was "to take her down." I got my own nervous parts to step back and helped her stay curious about why that part wanted to do that. It told her that she deserved to die, and it was going to make sure she did. Colette looked at me and said that it seemed like pure evil. I told her to just stay calm and curious so she could talk to it and we could see if that was true.

Colette: *Why do you think I deserve to die?*
Suicidal Part: *You just do, and it's my job to make sure you do.*
C: *What are you afraid would happen if I didn't die?*
SP: *I'm not afraid of anything!*
Dick Schwartz: Ask it what would be good about your death.
C: *OK then, why would it be good if I died?*
SP: *You wouldn't keep feeling good about yourself.*
C: *So, you don't want me to feel good about myself?*
SP: *Yes, because you're a worthless piece of shit and a waste of space!*
C: *What's so bad about me feeling good?*
SP: (after a long silence) *Because then you try*.
C: *And what's bad about trying?*
SP: *You keep getting hurt.*

Ultimately, the part revealed that it couldn't stand another failure: it would rather have her dead than disappointed yet again. Colette showed the part appreciation for trying to protect her from that outcome, and we asked for its permission to heal the parts of her that had been devastated in the past by disappointment.

Continued...

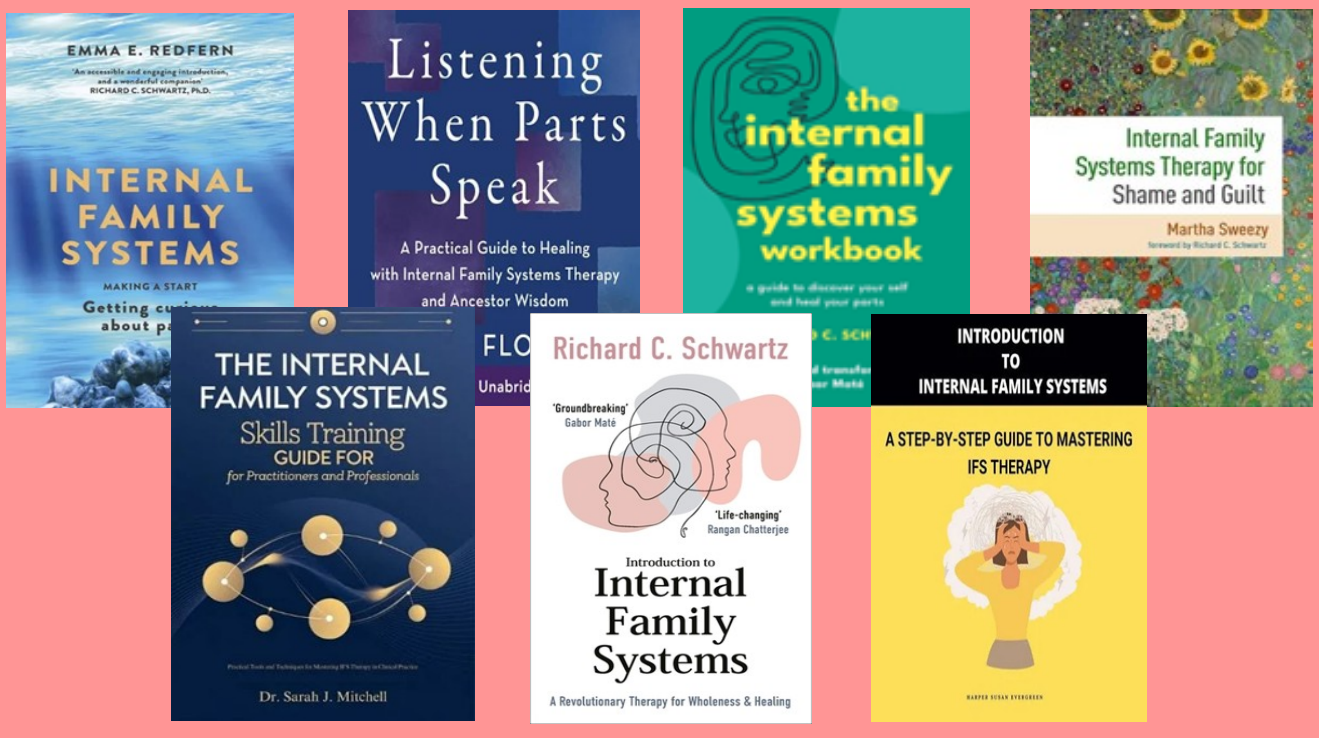
Fortunately, Colette's story has a happier ending than Pamela's. She realized that this wasn't a suicidal part per se, but another, tougher extreme protector part that had been a major player in her life. Because of its belief that pain and suffering were her destiny and any good thing coming her way had to be false and delusory, it had limited the amount of confidence or happiness she was allowed to experience and had resorted to sabotage when it felt things were going too well. Without the unconscious constraint of this saboteur, the trajectory of healing went steadily upward.

The difference in outcomes between Pamela and Colette was related to my differing perspectives on borderline personality disorder. What helped even more was my ability to notice the parts of myself that were triggered by Colette, work with them in the moment, and then return to self-leadership. Regardless of your orientation as a therapist, this ability to monitor the openness of your heart and quickly recover from a "part attack" is especially crucial when treating borderline clients. As my experiences have shown, clients' distrusting protectors are monitoring your heart, and they'll test and torment you or terminate therapy the moment they sense it closing.

One of life's great inequities is that so many people traumatized as children are reinjured throughout their lives because the original hurt has left them raw and reactive. It's inevitable that borderline clients will, from time to time, trigger feelings of fear, resentment, and suffocation in their therapists. Your recognition of what's happening inside you and authentic attempt to reconnect can become a turning point in the therapy. Many borderline clients have had little validation in their lives. When they've been in conflict with someone, they've typically been shamed and rejected for being too sensitive, emotional, or impulsive. As a result, they often carry the sense that they're doomed to be alone along with a battery of unusually reactive and extreme protectors.

These clients deserve to be in relationship with someone who, after initially being triggered, can regain perspective and see behind the explosive rage, icy withdrawal, or manipulative controlling to the pain that drives those behaviours. As you become aware of the parts that try to protect you from these clients and get them to let your inner self shine through, not only will these "difficult" clients become some of your most rewarding, but your level of self-leadership and compassionate presence will increase.

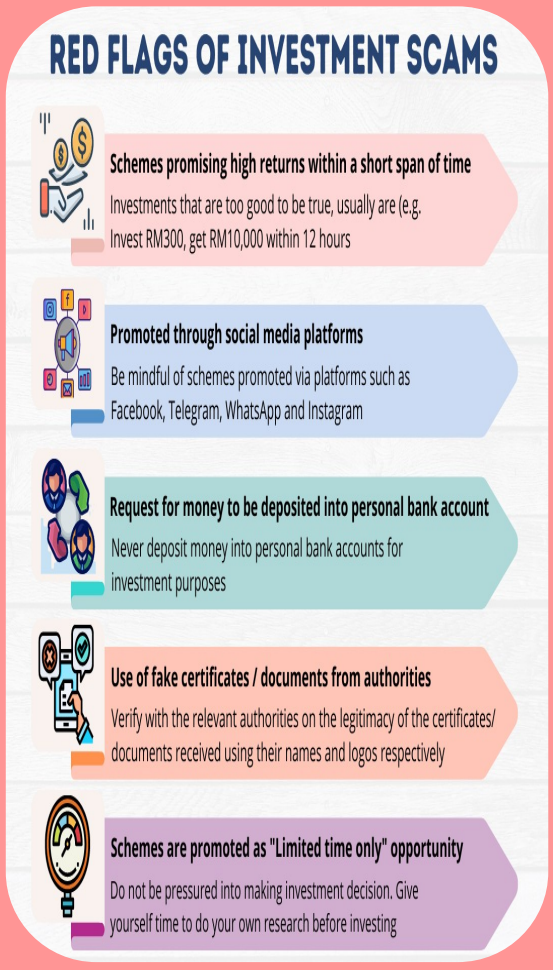
Richard Schwartz, Ph.D., director of the Centre for Self-Leadership and the originator of the Internal Family Systems model, is the author of *Internal Family Systems Therapy* and *You Are the One You've Been Waiting For: Bringing Courageous Love to Intimate Relationships*



Scams – a glossary

There are lots of different and confusing terms for different types of fraud, which makes things unnecessarily complicated. Here's a quick glossary so you know what they mean.

- Spoofing: This is where fraudsters use a bit of cheap technology to make it look like a phone call or message is from an official business or organisation – or even someone you know.
- Easy marks: Fraudsters trade lists of people who have fallen victim to fraud who are then contacted again by other fraudsters, sometimes pretending to offer to get your money back for free.
- Push payment/Courier fraud: Authorised Push Payment (APP) fraud is where you are tricked in to either transferring large amounts of money or handing over your bank details by fraudsters pretending to be your bank or the police.
- Boiler rooms: This is a type of fraud that uses pressure selling to get you to by worthless or non-existing investments or cryptocurrency. The fraudsters often use 'easy marks' lists to target victims of mis-selling or fraud repeatedly.
- Purchase scams: Fake adverts for retailers, often advertising on legitimate social media websites.
- QR codes: This is a 'quick response code', a square type of barcode that allows you to scan it with a phone and link to a website or data.



Parking scams

There are not just one, but two new types of parking scam operating at the moment! Both are devilishly simple for fraudsters to operate, so you need to be super cautious when paying in private car parks.

Some private parking firms have QR codes that you scan to make a payment. But crafty fraudsters have been putting fake QR codes on to stickers and attaching them to the signs, so you put your bank details into a fake website. What's worse is that a brand-new variation on these scams involve attaching a small, fake Bluetooth card scanner to the section of the payment machine that you tap with your debit or credit card. This then 'skims' your payment details.

The reason these scams are so effective is because paying for parking fees through an app or phone line is a massive faff in many instances. So, tapping or scanning seems much easier. But grit your teeth and download the official parking **apps** for parking companies and use them instead.

Continued...

Energy scams

There has been a big increase in fraudsters impersonating energy firms and the regulator Ofgem.

Scams are often seasonal. So as September rolls around and the weather becomes atrocious, it's natural that our thoughts turn to rising **energy bills** and affordability. There are a range of scam texts and emails being sent at the moment that 'spoof' numbers, so your phone says that they are from an energy supplier or Ofgem.

These messages may suggest you've been overcharged, and you can claim back a credit. Others might tell you that there is a better deal available. Some messages invite you to claim for a grant – playing on the actual grant and discount schemes operated by the government and energy suppliers.

Bank and e-payment scams

You may receive an email from 'PayPal' saying you had bought a certain item. Look closely at the email address. It may indeed say PayPal, but if you look closely, there may be an umlaut – two little dots – over a letter 'ä' in PayPal. Talk about hard to spot! In this case the email, which can look incredibly convincing, is probably a fake.

There's an epidemic of these emails doing the rounds at the moment from banks, card and credit providers and e-payment services. They are designed to shock you in to clicking the link attached with the email or message before you've had time to think. Always remember the golden rule: never click the link – go straight to the official website or app to check.

Phone scams

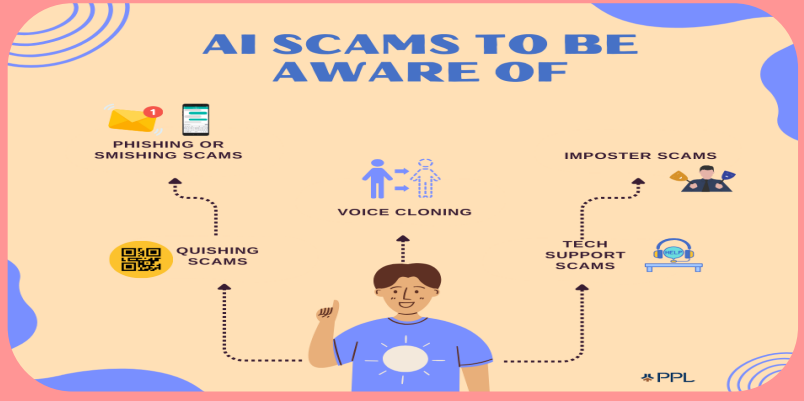
There seems to be a rise in mobile phone purchase scams at the moment. This is where fraudsters hack your mobile phone account or set up a fake one using your details.

They order expensive mobile phone handsets that are delivered to you. When you complain that you didn't order the phones, the scammer comes to your home pretending to be a courier company, collects the phones and leaves you with a massive debt.

Mobile phone companies know all about this scam, but they can be very bad at sorting out the problem. If the business isn't listening to you, threaten to go to the Communications Ombudsman. That will get their attention!

If you've been scammed…

Don't forget, the quicker you act the better the chance you stand of getting your cash back. If you've transferred money to a fraudster, call your bank asap or dial 159 – a number run by the free **Stop Scams UK service** - that will connect you to your bank or a leading retailer.



Source: ***One basic rule to stop scammers that everyone must follow***

Prison Stories

Canteen

by Sue Wheatcroft

TRIGGER WARNING

Friday was everyone's favourite day because it was when we received our canteen. We could order tobacco, brand-name toiletries, extra tea, coffee and milk, as well as sweet and savoury treats that we didn't get as part of our regular meals. My canteen hadn't arrived on the wing; it had gone to Healthcare and was sitting in the office. I asked an officer if someone would fetch it for me and she said she would do it. Sometime later, I asked again; I knew the officers were busy and wondered if she had forgot. I asked her politely, but she snapped back 'It'll have to wait, we're too busy'. OK, keep calm Sue, I told myself, but I knew that after a certain time it would be too late to send it back to stores if something was missing and then I would have to wait until Monday.

I paced up and down outside of the office. Louise came and gave me a cuddle; Aisha gave me some fudge. A sugar surge was perhaps not what I needed at that time, but she was worried about me doing something rash. I tried the office once more; Officer Serena was in there alone. It was 3.20pm and stores closed at 4pm. I asked if she was planning on getting my canteen any time soon. She said there were no Healthcare appointments. I said I didn't need an appointment; my canteen was in the office. If she was too busy, she could easily arrange for someone to bring it to the wing; officers were passing Healthcare all the time on their way to the houseblock. But she just repeated that there were no appointments.

I told her she was talking bollocks. She said I was getting an IEP for that. I told her to fuck off. She came to the door of the office and asked another officer to help her put me behind my door. I thought of spending the rest of the day in my cell without my canteen, getting angry and frustrated. 'I'm not going fucking anywhere', I said. I got hold of her wrists and pushed her back into the office. I didn't have a plan. She banged into a filing cabinet before the other officer grabbed me and threw me to the floor. He had pressed his personal alarm and several officers, including Jo and Kev, arrived.

Continued...

I was still hanging onto Serena, and she fell to the floor with me. Then, someone got Serena away and several officers were pinning my arms and legs to the floor. They grabbed my arm, which had been dislocated, and I screamed in pain. We were surrounded by prisoners and one of them, Keely, told them to be careful of my arm. The women were ordered back to their cells, and I was left alone with the officers. Kev told me they would get me up but if I made one false move I would be put back on the floor. They stood me up and I was escorted to his office.

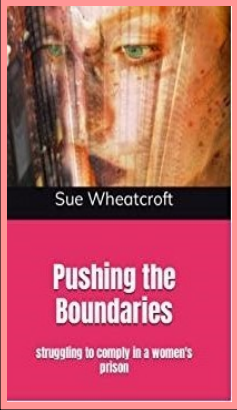
Kev went to see if Serena was alright. When he came back, he said her back was bruised. I had attacked one of his officers, he said, and he wasn't willing to take the risk again. I was going to Segregation. 'You know the score Sue, we've been here before, there will be an adjudication tomorrow morning'. I was escorted to Segregation with an officer each side of me, one at the front, one at the back, and another to unlock/lock the doors. Kev followed behind with Matt, the duty Oscar One. The cell was empty as usual, and I asked when I would be getting my belongings from the other two cells. 'When we can facilitate it', came the reply. In other words, I thought, we will leave it as long as we can just to wind you up. I had arrived in Segregation at 4pm Friday and had nothing except the clothes I was wearing until 8pm the next day, when they brought my belongings from Remand Wing. I didn't have my things from Healthcare and I still didn't have my canteen.

Sue x

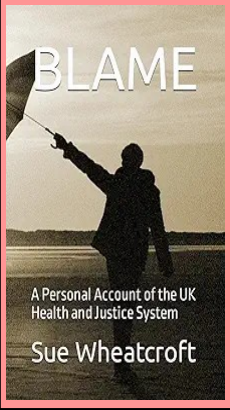
More prison stories can be found at:

Prison and Mental Health Stories by Sue – Personal Accounts of Health and Justice

. ..and in the following biographies...



The book examines the relationships between prisoners as well as their interactions with officers, managers/ governors, and healthcare staff. Also discussed are issues such as bullying, loneliness, boredom, anger, violence, and desperation, as well as friendship, compassion, community, and loyalty.



In this book, Sue highlights the ways in which mental health services let her down when she was most in need of help in managing her symptoms of borderline personality disorder. Sue pulls no punches when discussing how the lack of understanding and the stigma surrounding personality disorders can lead to a disproportionate amount of risk aversion within the health and justice system, and to injustice.

WHAT TO TELL MYSELF WHEN I'M FEELING DISCOURAGED

1. This is tough. But so am I.

2. I may not be able to control this situation. But I am in charge of how I respond.

3. I haven't figured this out...yet.

4. This challenge is here to teach me something.

5. All I need to do is take it one step at a time. Breathe. And do the next right thing.

How Does Childhood Trauma Affect Relationships? Understanding Your Adult Attachment Style

It might be surprising, but there is a strong link between the relationships you form as an adult and the very first bonds you experienced with a parent or carer. This connection is well supported by research. If you have ever asked yourself, "How does childhood trauma affect relationships?" or noticed patterns repeating in your adult life, the answer may lie in Attachment Theory.

The Blueprint of Your Bonds

Relationship scientist John Bowlby dedicated much of his work to exploring our fundamental need for 'Attachment'. His research revealed that this need is not confined merely to childhood; rather, it continues to shape our interactions throughout our lives.

Through extensive observations of parents interacting with their children, Bowlby identified several different types of attachment. According to his theory, the way we connect with our early caregivers creates a crucial "blueprint or map" that influences all our future relationships.

Secure vs. Insecure: What's Your Style?

Attachment styles can generally be grouped into two main categories: 'secure' and 'insecure'. As infants and young children, it is essential for us to feel that our caregiver is present, dependable, and provides us with a sense of love and security. Importantly, creating this foundation is not about achieving perfect parenting; it is about being 'good enough'. Most parents do not intend to cause harm, but often, their own behaviour is shaped by the attachment patterns they developed in their own childhoods.

Recognising the Lasting Impact in Adult Life

These formative experiences mean that the early dynamics of attachment can lead to certain expectations and behaviours in adult relationships. For instance, someone might struggle to trust others, feel anxious within relationships, or find themselves repeating unhelpful patterns without fully understanding the underlying cause. These issues underscore the lasting impact that early attachments have on future connections with others, manifesting in questions such as:

- How does a bad childhood affect relationships?
- How does childhood trauma affect marriage?

How does childhood emotional neglect affect relationships?

If you struggle to trust or experience anxiety related to intimacy, these feelings often mirror those deeply rooted, early dynamics.

What to do

Find a therapist who specialises in attachment difficulties. By working together, you can aim to:

- Understand your attachment style.
- Break free from patterns that do not serve you.
- Move towards relationships that better meet your needs and bring greater happiness.
- Boost relationship confidence.
- Explore change with support.

Source: How Does Childhood Trauma Affect Relationships? Understanding Your Adult Attachment Style

Martha's Rule

Martha's Rule is a patient safety initiative to support the early detection of deterioration by ensuring the concerns of patients, families, carers and staff are listened to and acted upon.

It has been developed in response to the death of Martha Mills and other cases related to the management of deterioration. Central to Martha's Rule is the right for patients, families and carers to request a rapid review if they are worried that their or their loved one's condition is getting worse and their concerns are not being responded to.

Martha's story

Martha Mills died in 2021 after developing sepsis in hospital, where she had been admitted with a pancreatic injury after falling off her bike. Martha's family's concerns about her deteriorating condition were not responded to, and in 2023 a coroner ruled that Martha, aged 13, would probably have survived had she been moved to intensive care earlier. In response to this and other cases related to the management of clinical deterioration, the then Secretary of State for Health and Social Care and NHS England committed to implement 'Martha's Rule' across the NHS.

What is Martha's Rule?

Martha's Rule recognises that those who know the patient best may be the first to notice changes that could be an early sign of deterioration, and the importance of listening to and acting on the concerns of patients, families, and carers. It is being implemented in both adult and children's inpatient settings in England.

The 3 core components of Martha's Rule

1. Patients will be asked, at least daily, about how they are feeling, and if they are getting better or worse, and this information will be acted on in a structured way.
2. All staff will be able, at any time, to ask for a review from a different team if they are concerned that a patient is deteriorating, and they are not being responded to.
3. This escalation route will also always be available to patients themselves, their families and carers and advertised across the hospital.

Empowering patients, families, carers and staff

Martha's Rule actively encourages patients, families and carers to tell staff if they are worried a health condition is getting worse. They may notice small changes that could be early warning signs of deterioration before they show up in routine measurements. If, after speaking to the care team, they remain worried and feel their concerns are not being addressed, they can call a dedicated number for a rapid review from a different team. Martha's Rule also empowers staff to call for a rapid review if they feel their concerns about a patient are not being responded to.

Evidence suggests Martha's Rule is saving lives

Early evidence suggests Martha's Rule is saving lives. Data from September 2024 to July 2025 shows 5,583 Martha's Rule calls were made, with the highest proportion of calls (72%) made via the family escalation process. 2,277 Martha's Rule escalation calls (41%) related to acute deterioration. Of those, 265 calls resulted in potentially life-saving transfers of care, including:

- 99 urgent admissions to high dependency or intensive care units
- 55 resulting in transfers to another enhanced level of care or to a tertiary centre

Changes in treatment were also noted for a further 793 calls, for example the introduction of a new medication such as an antibiotic to treat infection, investigations including scans and referral for specialist input. Where calls did not identify deterioration, they are still supporting staff to provide better care and address concerns.

Continued...

The data highlights the importance of listening to patient and family/carer concerns and how Martha's Rule can work alongside existing physiological scoring systems to increase the sensitivity of identifying and responding to acute deterioration. Please note that these data have been published as management information. Data source: the Martha's Rule Data Collection. You can find the latest data on the Martha's Rule data collection web page.

Implementing Martha's Rule

In May 2024, Martha's Rule began being introduced at 143 phase 1 pilot sites within NHS acute trusts across England. Following positive results from the first year, phase 2 of the programme commenced in April 2025, expanding Martha's Rule to all remaining sites that provide adult and/or paediatric acute inpatient services. As part of phase 2, the programme is also supporting the testing of Martha's Rule in a small number of maternity and neonatal units, emergency departments, community hospitals and mental health settings. Monthly data returns and case studies from the Martha's Rule sites are building a national picture of how Martha's Rule is being implemented in practice. This is enabling the national Martha's Rule programme team to assess its impact on patient safety, identify key learning, and support wider adoption. There has also been a focus on accessibility, ensuring this service is available to everyone and providing hospital staff with the appropriate training to support patients, families and carers to use Martha's Rule.

Leadership and support for Martha's Rules sites

The Martha's Rule Programme is led by the National Director of Patient Safety in NHS England. The implementation is being led and facilitated by the National Patient Safety team in partnership with the National Nursing Directorate. The programme is delivered collaboratively with colleagues across NHS England, including the Children and Young People team, critical care networks as well as teams specialising in mental health, community, maternity, neonates and emergency medicine. Through the programme board we are also working collaboratively with patient safety partners, the Care Quality Commission, professional regulators, Royal Colleges, the Healthcare Race Observatory and the Patient Safety Commissioner. Martha's Rule sites receive comprehensive support through the national Martha's Rule programme team at NHS England and locally through the patient safety collaboratives. This includes implementation guidance, regular learning events, peer support networks, and dedicated resources to help overcome challenges.

Communications, key messages and branding

Independent audience research and testing around messaging, branding and the identity of Martha's Rule has taken place to support providers to ensure how they communicate about the programme is done in a way that resonates most with patients, families and staff across a diverse range of communities and age groups. This includes specific messaging and communications materials for adult and children's healthcare settings. A national communications toolkit was published in April 2025 on the Department of Health and Social Care's Campaign Resource Centre which pilot sites are encouraged to use.

How Martha's Rule fits with wider work to identify and manage deterioration

Better identification and management of deterioration is one of NHS England's key priorities in improving patient safety. The PIER approach (prevention, identification, escalation and response) views deterioration as a whole pathway and will support effective management of acute physical deterioration. The introduction of Martha's Rule comes alongside other measures to improve the identification and response to deteriorating patients in a healthcare environment, including the National Early Warning Score (NEWS) and the new early warning system for staff treating children that was launched in November 2023.

martha's rule
detecting deterioration

Martha's Rule builds upon learning from NHS England's Worry and Concern Improvement Collaborative, which began in 2023 across 7 regional pilot sites. This earlier initiative tested and developed approaches for patients, families and carers to escalate concerns about deterioration and to have their observations about their own or their loved one's condition formally recorded in health records.

Source: *NHS England » Martha's Rule*

What I wish people knew about borderline personality disorder

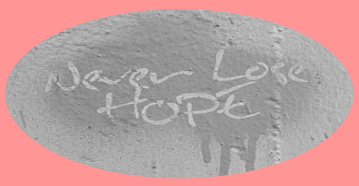
by Laura, 21

I was diagnosed with BPD in 2017, after being in psychiatric hospital for a while. When I first heard about BPD, I went online and printed out a load of information on it and highlighted almost the whole of each page. It suddenly made so much sense. All the things I hadn't wanted to talk about, all the feelings that didn't make sense to me, things I couldn't put my finger on – they were all there on a few pages. Although the information said just 1.6% of us share this experience, it still made me feel so much less alone than I had.

My experience of BPD

I felt ashamed and abnormal when I would feel certain things: such as feeling suicidal over seemingly trivial events or interactions. Some days, I didn't feel real: believing that the emptiness of being so unwell had consumed all of me so much so that there wasn't even really a true 'me' anymore. I desperately wished I could undo all of it; but every day was a drop deeper than the last, and it happened so suddenly. I never spoke about the details of what I felt and never thought I would. I worried about how it would look and how far people would drift from me, because if it didn't even make sense to me, how could it make sense to anybody else?

What I wish people knew about BPD



But overtime I have started to talk about how I feel, and there are certain things I want people to know about BPD.

- Often, the tiniest thing can feel like an enormous weight crashing down on you in a split second. These 'tiny' things, the things that other people might not notice, can feel devastating. But the overriding thing to remember is that it is no one's fault that some things hurt more than they might for other people. It's just important to communicate openly to interrupt the thoughts that might have begun spiralling for us.

- Things aren't stable, or unstable, all the time. Feelings can be fleeting or last a long while; they can be distressing, or feelings of euphoria – about an event, a situation, a person. People with BPD might feel one thing so deeply, then with the slightest change or a split second, it can switch to the opposite or disappear altogether. I have had very long periods of my life where I often forgot what it was like to feel the worst parts of my BPD. Understand that it is not a contained period of 'illnesses', but one that is ever-changing throughout life – and it won't always be at its worst.

- People with BPD don't want to be isolated in relationships with others, even if sometimes we do that ourselves. The first question that appears when you google 'BPD relationships' is 'Can a person with BPD really love?' We can. And while it's important to acknowledge the pain that those around us might experience as a result of seeing a loved one experiencing mental illness (as is the case with the friends or family of anyone struggling with their mental health), it is not always that way. Some relationships can be harder for us, but they aren't impossible. If you have BPD, you are capable of loving and being loved in return – and it won't always be tumultuous.

- The final thing I want people to know is how important it is to be honest. I spent a really long time not talking about the things that hurt because I was afraid. If you have BPD, you aren't alone in your thoughts or fears. There are people who understand and want to be there with you through it, no matter how ugly it can get. And for people who know someone with BPD, please be patient. Get support for yourself if you are finding it tricky and know that we never want to hurt the people around us or push them away. There is support out there, even if you feel so alone.

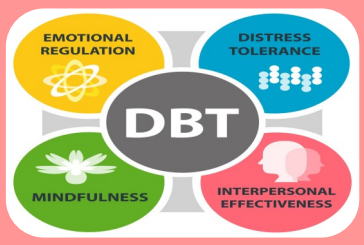
Source: *What I Wish People Knew About BPD | Real Stories | YoungMinds*

A BPD Recovery Success Story

by Holly Marie

"I always knew there was something different about me. I loved deeply, got attached quickly, and suffered greatly at the slightest rejection. I had suicidal ideation at least once and month and cut myself on a daily basis. My friends were concerned. My family was distraught. No one knew what was going on with me."

It was about 6 years ago, when I was first diagnosed. It was right after the most traumatic thing, which could happen to a first-year special education teacher, happened. I'm not going to get into that now, but know that it played a role in my final diagnosis. *"You have borderline personality disorder."* Those were the words of my therapist of one year, Sarah. I felt quick relief, and sudden despair. Thoughts of, "Oh, what a relief! There is really something wrong with me", changed to, "you mean this is something that has no easy fix like medication?" I felt afraid. I thought wow, I'm going to have these attachment issues my entire life? I'm going to be self-harming my entire life. I'm going to be loving and then suddenly hating on someone my entire life. I can't live like this!



It was 2008, right after my diagnosis, that I was first introduced to *Dialectical Behaviour Therapy* (DBT), a therapy where you focus on changing your thoughts about my order to positively influence your behaviours. When I was first accepted into a DBT program, I didn't know what lay ahead of me. I didn't know that I would eventually be kicked out of my first DBT program, due to clingy and negative behaviours I showed towards my DBT therapist.

For those of you who don't know, one characteristic is moments of extreme idolisation and then devaluation of people. People with BPD often have one person they attach onto, who becomes their 'favourite person'. Unfortunately for them, each of my therapists had/have taken on that role. And yes, I used the word each. I have now been through four different therapists. Three ultimately terminated me because of my BPD behaviours. They just didn't have it in them to take anymore, "I hate you!" And "you should die!" when I did not get my way with them.

"I don't want to make BPD out to be this horrible mental illness, and all who have it are evil. What I do want to get across is that BPD is not an easy diagnosis to deal with."

It takes years of commitment to therapy and finding a just right therapist to work with. After my third termination, I just about threw in the towel with therapy. Being terminated was not easy. I spent once a week with this professional pouring my heart and soul into them, only to be terminated in the end when I pushed them too far. I almost gave up. I almost said, "this is it, this is my destiny, and I am bound to live a miserable life." But I didn't. And the reason, I had just been offered a dream job. A special education teacher.

I knew, just knew, I could not continue on my negative life path. I couldn't continue the path of valuing and then devaluing others. I couldn't continue the daily self-harming and weekly suicidal ideation. So, I decided to start the search. I sent out endless amounts of introductions to therapists I found on *Psychology Today*. I took the time to explain my struggles, and the potential 'toxicity' that came with working with me. I received multiple rejections, from therapists who felt like they couldn't deal with me and my BPD. Then one day at the end of August, I reached out to Dr. W., not knowing that she would become the perfect therapist for me. I still remember the day she responded to me. I still have the first email. She was open and willing to possibly take me on! It was too good to be true! So, I responded. I confessed and admitted to her my BPD tendencies. I received this response, "Hi Holly, yes, I believe we could work together."

Continued...

That brought me to the beginning of September 2016. I followed through with meeting with her and almost decided to never go back. I had never met with a therapist who centred the therapy around me. I had never talked as much as she wanted me to talk at that first session. I didn't think we could be a fit. But I decided to go back, and I haven't gone more than two weeks without seeing her since then.

Dr. W has endured a lot. She has endured my clinginess. She has endured so many, "I hate you's!" She has endured so many, "go get hit by a car and die!" But what I said to her never got under her skin. She always maintained her professionalism and kept seeing me. In fact, after she had to put me inpatient due to a suicide attempt just 8months after I began seeing her, she promised me this, "Yes, see you Wednesday and for all future appointments I am not terminating you." She promised me that we will end therapy on MY schedule. We would end therapy at MY request. Wow! That was foreign to me. I never had a therapist promise to not terminate me for bad behaviours. I never had a therapist promise she would not "get sick of me." The reason I bring up my story about Dr. W. Is because she has really helped shape me into me. I have now been working with her for four years. She has stuck with me through my suicidal ideation, which comes fewer and farer between now. She has stuck with me through self-harming. She had encouraged me to grow. And she has encouraged me to become the best Holly that can exist. Dr. W. believes in me. Dr. W. pushes me. And it is thanks, in part to, Dr. W. that I am as strong as I am today. Prior to this last year, I struggled with using my skills. I was overly reliant on Dr. W. To get me through crisis situations. I was experiencing a crisis moment at least once a week.

But now, I am working with Jade and Dr. W. to learn and apply the DBT skills in my life on a daily basis. It has taken me three different DBT programs in order to be able to independently apply the DBT skills Remember how I said people who have BPD are not evil? People with BPD just struggle more than the typical person. *My story is living proof that those with BPD can work hard to get through struggles.* Within the past four years of working with Dr. W. I have now met three meaningful milestones. Three years without being placed inpatient; two years without cutting; two years without a nasty interaction with Dr. W. I don't want to give all the credit to Dr. W. Though. Remember DBT that I spoke of earlier? It took years and years and multiple different DBT groups for me to become familiar enough with the DBT skills. I went through three different DBT programs and six different therapists. Today, I have come so far from who I was 7.5 years ago when I had the most traumatic day in my life. I am a successful special education teacher making a difference in the lives of second graders who have special needs. I know that I am that positive role model in their lives. Also, I have mastered relationships with friends and family. My relationships are the best they have been in the longest time. I use skills to get through intense time, and I rely slightly less on Dr. W. *I want everyone who has read this far to know, things won't always be easy, but please, please don't give up.*

Now here are some tips I'd like to give you. These have really helped get me as far as I have come. Take the time and be picky about finding a "just right" therapist who clicks with you- be honest about what you are looking for and what you are not. This relationship will be the cornerstone of your therapeutic journey. Develop your support network, NAMI, DBT skills groups, Facebook groups, friends, family grow your support network, so you have a wide variety of people to turn to in crisis .Never, ever give up, fight through the intensities, because to someone you are their "earth angel" Commit to learning and applying DBT skills. Be willing to give it your all. Be open-minded with learning the skills and applying them to your life. Make a commitment to be the best person you can be through the use of DBT skills. Develop a wide array of coping skills, these will help when you are down and feeling the worst.

Don't be ashamed of your mental health concerns. Remember, you are a warrior, and you have totally got this!

Source: *A BPD Recovery Success Story*

https://www.facebook.com/groups/learndbtskills

📢 Call for Participants 📢

Do you have an adult child with a **Personality Disorder**? Have they been engaged with the **Criminal Justice System**?

Families are often left to cope alone – your voice matters.

I'm looking for volunteer parents, like me, to share their experiences of having a child with a Personality Disorder who has engaged with the Criminal Justice System.

Your contributions will be *anonymised* and will help highlight the need for support, prevention, and change.

To enquire, scan QR code and email
T.DHoker@2024.ljmu.ac.uk

This research is being undertaken as part of doctoral studies - you are under no obligation to participate and may withdraw at any time.

Researcher: Trisha D'Hoker, School of Law and Justice Studies, LJMU

This research has received ethics approval from LJMU. Any comments or concerns can be forwarded to Dr Jayne Erlam, j.erlam@ljmu.ac.uk

Find full details of what partcipation will include at this QR code <<<

LIVERPOOL JOHN MOORES UNIVERSITY

"Not every difficult trait means someone has a personality disorder, but some patterns go beyond quirks or bad habits"

by Ashley Cropper

When certain behaviours show up consistently, across many situations, and cause distress to other people or the person themselves, they can sometimes point to deeper psychological struggles. Personality disorders can definitely be hard to spot. In fact, they're often masked by charm, intensity, or what looks like confidence.

Here are some behaviours that, if constant and problematic, may suggest the presence of a personality disorder, especially when they impact relationships, self-perception, or how someone functions day to day.

How much do you agree with the following statements?

They constantly see themselves as the victim

Some people always seem to be on the receiving end of unfair treatment, no matter the situation. Even when they've clearly contributed to a problem, they frame it in a way that puts all the blame on other people. This chronic victim stance can feel manipulative, but it often stems from deep emotional patterns they might not even recognise.

In certain personality disorders, particularly borderline and narcissistic types, this belief of being constantly wronged becomes part of their identity. It makes accountability tough and relationships tense. People eventually grow exhausted from always having to be the "bad guy" in their narrative.

They flip between idealising and devaluing other people

One day you're their favourite person, and the next you're the enemy. People who alternate between extreme admiration and sudden rejection often struggle with emotional regulation and a fractured sense of security in relationships. These changes aren't always based on logic, either. They're emotional reactions to perceived closeness or threat.

As it turns out, black-and-white thinking is a core feature of borderline personality disorder, but it can appear in other conditions too. It makes stable connection pretty much impossible because trust and affection are tied to moment-by-moment emotions, not consistent reality.

They can't handle even mild criticism

Everyone gets defensive sometimes, but when someone reacts with rage, withdrawal, or deep shame over gentle feedback, it can point to deeper instability in how they see themselves. They may hear criticism as proof they're worthless or unloveable, not just that they made a mistake.

Such extreme sensitivity can be linked to narcissistic, borderline, or even paranoid personality traits. The problem isn't the feedback; it's what the person believes it means about them. That belief can distort every interaction that follows.

They manipulate people to get emotional control

Some people resort to guilt-tripping, gaslighting, or twisting facts to keep people close or avoid discomfort. These behaviours are often subtle and hard to call out directly, but they leave people feeling confused, anxious, or unsure of what's real.

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Emotional manipulation can be a sign of several personality disorders, particularly narcissistic and histrionic types. It's not always intentional or malicious—it can come from a deep fear of abandonment or being seen as weak. But either way, it's damaging over time.

The way they see themselves constantly changes

One week they're planning to change careers, the next they're questioning their entire identity. People with unstable self-concepts often feel like they're floating—trying on new personalities, goals, or beliefs in search of something that finally feels like "them."

This instability is common in borderline personality disorder but can also appear with identity issues tied to other diagnoses. Without a solid core to return to, they often define themselves through other people or through constant reinvention, which creates chaos in relationships and within themselves.

They're impulsive in ways that create fallout

Spending money recklessly, jumping into risky sex, quitting jobs on a whim, or picking fights out of nowhere—impulsive behaviour that repeatedly damages their life or relationships can be more than just poor judgement. It can be a sign of struggles with impulse control rooted in emotional dysregulation.

In disorders like borderline or antisocial personality disorder, this impulsivity is often a way to escape discomfort or chase a feeling of control. The trouble is, it tends to create more instability, leading to a cycle of regret, apology, and repeated chaos.

They have a chronic need to be admired

There's nothing wrong with wanting to be liked, but when someone needs constant praise, recognition, or attention just to feel okay, it can point to narcissistic tendencies. It's not always loud or braggy, either; it can be subtle, like fishing for compliments or overreacting to being overlooked.

The core issue is often a fragile sense of self-worth. Without external validation, they may spiral into insecurity, envy, or passive aggression. This dynamic makes balanced relationships hard to maintain, especially when they feel other people aren't giving them "enough."

They hold intense grudges or can't let things go

Some people never really forgive, no matter how much time passes. They hold onto past wrongs, bring up old arguments, or seek revenge in ways that feel disproportionate. This can stem from rigid thinking and an inability to process complex emotions like disappointment or betrayal.

In certain personality disorders, especially paranoid and narcissistic ones, forgiveness isn't a natural option. Instead, it's seen as weakness. Holding grudges becomes part of their identity, and they may even rewrite history to make themselves seem like the only rational party.

They isolate themselves but still feel rejected

People with avoidant or schizoid traits often pull away from other people, but still carry a deep sense of being misunderstood or left out. It creates a confusing loop in which they withdraw to protect themselves but then feel resentful or abandoned when people don't reach out.

This push-pull is challenging for relationships, to say the least. Even well-meaning friends or partners end up feeling like they can never do enough. What looks like detachment on the surface often hides a deep craving for connection that they don't know how to express safely.

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They view most people as threats

People who are constantly suspicious, distrustful, or reading into hidden motives may be dealing with more than just anxiety. If they interpret harmless comments as insults or believe other people are always trying to hurt or use them, it can signal deeper paranoia.

This worldview shows up most in paranoid personality disorder, but it can overlap with other conditions too. It makes closeness nearly impossible because trust never really forms. Every relationship feels like a test or a trap, which leaves them feeling isolated and justified in their suspicion.

Their moods change dramatically and often

Quick, intense changes in emotion, going from euphoria to rage or deep sadness in minutes, aren't just moodiness. When this happens a lot, and for reasons other people struggle to understand, it may suggest emotional dysregulation tied to a deeper issue.

Borderline personality disorder is most known for this emotional rollercoaster, but other people can experience it too. The person often feels like a passenger in their own emotional ride, reacting to perceived slights or changes in connection as if everything is at stake.

They rely heavily on one person for emotional survival

Being close to someone is normal, but needing them to soothe every emotional low, validate every decision, or carry their self-esteem entirely puts immense pressure on the relationship. This kind of dependency often stems from deep-rooted fear and insecurity.

People with dependent or borderline traits may become so emotionally fused with someone that any distance, real or imagined, feels devastating. The relationship becomes their lifeline, which can lead to jealousy, control, or panic when they fear being left behind.

They create drama or chaos to feel "alive"

Some people seem to stir up tension everywhere they go, not always intentionally, but with a kind of restless energy that disrupts peace. This might include starting arguments, jumping into unstable relationships, or acting out just to avoid boredom.

In certain personality disorders, chaos becomes a coping mechanism. It distracts from emotional emptiness or inner conflict. While it may feel like excitement in the moment, it usually leaves a trail of confusion, broken trust, and emotional fallout behind.

Source: *People Who Showcase These Behaviours May Have A Personality Disorder*

Whether you agree or disagree with the previous statements, would you like to have your say?

Get in touch with Sue at derbyshireborderlinepd@gmail.com if you would like to write your thoughts on this, or any subject, for the next newsletter


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