**Audio Transcript for Episode 507: "Borderline Personality Disorder: Seeking the Gray" with Genevieve Jacobs and counselor Patrick Miranda**

*Please note: This transcript has been lightly edited to remove filler words or sounds.*

**GENEVIEVE JACOBS**: I think that you know, the perfect words to describe BPD is just emotional dysregulation because that's exactly what it is. And so, in all my relationships, everything in life, I just feel everything much more heightened, whether that's good, or whether that's bad. And you know, on the good days, that's great, and things are exciting. But on the bad days, they're the worst days, and they feel like you're never going to be able to get out of them.

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**CHAD MOSES**: You’re listening to the To Write Love on Her Arms podcast, a show about mental health and the things that make us human. I’m your host Chad Moses, and in each episode, we’ll be talking about the things that can often feel hard to talk about, like depression, addiction, self-injury, and suicide. We’ll be sharing stories and exploring big themes like hope, healing, and recovery. If any of the topics we discuss or the stories we share feel too heavy for you, know that it’s OK to pause, to restart, or to stop altogether. As we discover new stories, we hope to remind you that your story is important.

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**CHAD**: Borderline Personality Disorder. It has been deemed a heavy diagnosis. One that has been unfortunately branded with characteristics such as manipulative, self-destructive, unstable, selfish, and untreatable. It is described as involving patterns of wavering interpersonal relationships, a distorted sense of self, and emotional reactions that are characterized as intense.

Damn, just reading those words stings. But as with all things, it’s our hope to look past labels in order to focus our attention on people, on the person, on perhaps you or someone you love.

So today, we’re going to confront some truly harmful labels, reiterate that this diagnosis, contrary to popular belief, is indeed treatable, and that amidst the black and white thinking, there is a middle space of gray to be found and known. In a way, it’s ironic that a condition defined by black and white thinking can be received in black and white terms. So let’s be clear: borderline personality disorder is not your identity. It’s not a personal definition and it’s not a mandate to waive your right to personal connection. Within every person touched by BPD, there is nuance, beauty, and truths that run deeper than a diagnosis. To help us tackle all of these things and more, we’ll be joined by Genevieve Jacobs.

Gen is a resident physician navigating the roles of both doctor and patient with her diagnosis of borderline personality disorder. She is passionate about addressing the stigma associated with physician mental health and seeking help. Gen currently lives in Ontario, Canada, with her partner and their dog. Outside of work, you can often find her kayaking, adventuring with her pup, or working on being a better plant mom.

At the halfway point, we’ll talk to counselor Patrick Miranda about the more clinical side of BPD.

These conversations were illuminating, humbling, and humanizing and we can’t wait for you to hear them, so we won’t. Let’s get started.

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**CHAD**

For those of you that are familiar with To Write Love’s blog, perhaps you recognize the name Genevieve Jacobs, she has been so kind in offering her story, her perspective and her lived experience on our blog. And today, we could not imagine this conversation without her voice being a piece of it. Today, we are talking about borderline personality disorder. And I guess we'll just start there, Gen, at what point did the term or the diagnosis or just even the idea of borderline personality disorder enter your line of sight?

**GENEVIEVE**

It was actually much later than you would think. So I have long struggled with mental health challenges. And it became a lot more pronounced in my post secondary schooling. But it really wasn't until I was in medical school, that I became familiar with borderline personality disorder. And the conversation started to, you know, revolve around whether that was an appropriate diagnosis. Because it is a diagnosis that's so highly stigmatized, and chatting with my psychiatrist about this, you know, she introduced it very delicately, that saying, you know, that she was “suspicious”, so to speak of some borderline traits. And that was a big adjustment after hearing that, because even myself, you know, I talked in my blog posts about how stigmatized it is, and especially within the world of medicine. And so it was a really scary thing for me to hear initially. I remember even, you know, discussing this with my partner afterwards, who's also in medicine, and him being very hesitant, and hearing it and saying, you know, what, no, it's probably just this, it’s probably just this, I don't think you have this. And, you know, we had a lot of really in depth conversations about it, because he had expressed it, he was afraid, he didn't want me to have this label, and to have it affect, you know, my career path, my personal life, my relationships with those around me. And I definitely shared that fear at that time as well. But from, you know, working with my psychiatrist, a lot of self reflection, it became quite apparent that it, you know, it was my diagnosis, I did have borderline personality disorder.

**CHAD**

I think it's very poignant and very interesting that when you mentioned having this discussion with your partner, the phrase that you chose to use was concerned that you would be stuck with this label. But to kind of put human skin on this, how does BPD show up in your day to day existence? What does it mean to you to be someone living with borderline personality disorder?

**GENEVIEVE**

I guess a lot of what I learned about it, and a lot of what I learned about how my diagnosis of BPD affects me with a lot of it was in retrospect. And so looking back at my relationships with my family, with my partner, looking at these periods of really high stress and high conflict that I had in my life, looking back, and being able to recognize, you know, some of those characteristics. And so, viewing everything in black and white was a big, big thing that stuck out. I would really just fixate on small things, and it could change my entire view of a relationship or view of a person. And a lot of times more often than not, it turned into feelings of low self worth for myself, as opposed to, you know, anger towards others. Even if I recognize that, you know, I was very angry about whatever conflict I would internalize a lot as this is because I'm not good enough. This is because, you know, I, my personality, who I am as a person isn't good enough for these people to want to be with me.

**CHAD**

I think that that's one huge thing that as people kind of wrap their mind around what it looks like to live with BPD. Well, to live with anything, to live with a diagnosis or a non diagnosis means that you're living in the presence of other people so it can easily shift from what my mental health challenge is to how this is perceived by my friends, by my family, by the people I've let into my story. It sounded like you were saying something that it felt a lot like your relationships became one sided, but not in a, in a selfish way. But it seems like BPD made you believe that it was mostly on you to carry out the health of any relationship.

**GENEVIEVE**

Yeah, I think that's absolutely accurate. And, you know, just like you had said, the lens through which I view those relationships or digest those relationships. And I think that you know, the perfect words to describe BPD is just emotional dysregulation because that's exactly what it is. And so, in all my relationships, everything in life, I just feel everything much more heightened, whether that's good, or whether that's bad. And you know, on the good days, that's great, and things are exciting. But on the bad days, they're the worst days, and they feel like you know, you're never going to be able to get out of them. Because I want to put so much into my relationships and because I am so invested in those around me and those that I care about, I think that I would often and still continue to do at times, set unrealistic expectations for what should be received in return, so to speak. And so with, you know, those snap judgments I talked about earlier, everything being black and white, something very, very innocent and very innocent can be taken out of context. And it just led to a ton of distress, when, you know, just perceiving a person's entire viewpoint of me, so to speak as being viewing me as someone who is, you know, selfish, you know, over, not over invested but expecting too much and expecting more support from others than they're able to give, which I think is a really important recognition, as well. And so that mismatch between my expectations and reality was very distressing and was a huge thing that I've had to, you know, continue to work on and overcome.

**CHAD**

I love how you laid that out with this is a battle case by case on expectation versus reality, which is not altogether unlike people that don't live with BPD as well. like this, this is ultimately something that is relatable. And then we're just talking about levels of varying frequency and severity. And before we get into the blog, just a quick segue, I'm curious on how you first learned about To Write Love on Her Arms.

**GENEVIEVE**

So it was very close to the beginning that I heard about To Write Love on Her Arms very, very early on, and 2006-2007. And a lot of my initial exposure was through church. And I had been really involved in my youth group at my church at that time. And I really just, you know, I wanted to know more about it. And there was something that really resonated with me, the entire idea of, you know, normalizing these conversations, putting names and faces to these conversations, and being able to see for the first time in my life, that there were people who did feel like me. And I remember, you know, just reflecting before, thinking that one of the biggest ways that I expressed myself back then, and still, to some degree now is through a lot of the words of others, and the clothes that I wear, and the music that I listen to, and I've been super thankful now that I've gotten to use my own voice through To Write Love on Her Arms, but for many, many years, being able to read those stories, resonate with them feel heard, and feel like I wasn't alone. Well, still, maybe not being comfortable enough at that time to express you know, my own experiences, my own thoughts, I couldn't away still be and serve as a bit of a normalization of these ideas and a message of hope. And so that would be, you know, with my millions of To Write Love on Her Arms shirts, and the different things I could see and share online, it had been a really, really big support, and was one of the first ones that I think I had when you know, there wasn't anyone else that I could have been on.

**CHAD**

It's only recently have we taken time to specifically dive into this. This is one of our first podcasts about this. And you're the author of a couple of the blogs, and one of those blogs is living with BPD. And you mentioned how people and society as a whole often characterize this challenge. And the person who deals with it as being quote, “manipulative, self destructive, unstable, selfish, and untreatable.” And we can all admit that those are some heavy words. That's a heavy burden to bear. Can we address how wrong and hurtful those labels are? And what are some of the myths that you want to challenge here with an open mic open forum.

**GENEVIEVE**

You know, I'm privileged in the sense that I can practice medicine, but I get this really unique insight into BPD. Where, you know, I have my own lived experiences and I see it from that lens, but I also see it through the lens of, you know, caring for patients and hearing about their experiences and what it has been like for them because it can be so different. And so I think that's one of the big things that these stereotypes, these terms associated with BPD, one of the big things that they do is they deter people from, you know, wanting to get help when they need it. And so I think that from my own experiences, personally, it delayed my diagnosis, my denial of you know, what I could have this label, I could have this diagnosis, all I had heard, after, you know, being initially introduced to it were horrible things, which was really, you know, off putting, but it was scary. It made me very afraid. And like I'd mentioned earlier, you know, being able to see it from the perspective of medicine and my partner doing the same, he had expressed that fear that I would have a lot of negative repercussions, if I were to pursue a diagnosis, or continue, you know, to entertain that thought. And so I think that that stigma is really damaging, because it's hard enough to go and get help to begin with, it's hard enough to even just start to have those conversations. But continuing to have those conversations and give yourself what can be viewed as a permanent label, or something that's very poorly understood and very demonized by a lot of society, is very, very scary. But for myself, if I never would have been able to put that name to it, I don't think I would have been able to heal the way that I have, I don't think I would have been able to pursue the right mode of treatment, that I needed to address these issues. So I think it can be incredibly dangerous. And from the other side of this, we see so many times using that BPD lens. Now, once someone has, you know that as part of their past medical history, it can be such a determining factor in the way that they're viewed by their healthcare providers. And honestly, the level of care they receive, because the stigma and the bias within medicine is absolutely real. And so I think that those are just a couple of the examples of how harmful that can be, and off putting to someone wanting to get help and be able to get that help, because of the fear that comes along with that. And, you know, thinking about the other myths about BPD there's definitely a couple of them that hit quite close to home. And, you know, one, just being that diagnosis of borderline personality disorder, you have all of those words that, you know, were described earlier, manipulative, untreatable, selfish, viewing everyone with the same perspective. And you know, everyone with borderline personality disorder, feeling the exact same way as something that's dangerous, but something that's very often done, you take those traits, and you apply them to you know, anyone you know, what that diagnosis is, and it's just not true. I think that there are just such a wide variety of people with their own unique experiences, their own stories. And, you know, BPD is a piece of that, yes, but it doesn't define who someone is entirely. And, you know, another thing would just be that with that instability with all of those, your negative traits that are described, that you can't have and maintain meaningful relationships, and I just absolutely think that that's not true. I have been selective myself, you know, and disclosing my story and my diagnosis to people that I trust, and people that, you know, that care about me and I have relationships with. And in some ways, of course, it's been a challenge, you know, coming to address that coming to, you know, revisit these expectations that I have for these relationships, and that my friends and my loved ones have for these relationships. But I don't think that it prevents me from having those deep, meaningful relationships.

**CHAD**

I could easily take this entire podcast, just praising you and your bravery with your story and disclosing some of these moments. But I do want to hop back to one of these really hurtful words that you mentioned, which is “untreatable.” In the very recent past, BPD has been seen as something that's difficult to treat. But through newer and more evidence based treatment modalities and different ideas and tools and technologies that are being developed, people with BPD are finding their symptoms to be less intense, and that their lives can be more manageable. Would you be able to give us a view into what those levels of care and treatment have looked like in your experience?

**GENEVIEVE**

So I think that you hit on something incredibly important there that, you know, is a treatable condition. And it's something that you can recover from looking at my own treatment. A big first step was honestly just coming to terms with a diagnosis. And accepting that, you know, this is, this is the deck of cards that I've been given. And, you know, this is I do have a diagnosis of borderline personality disorder. And that was a big thing. Because with a lot of the treatment for BPD, it takes a ton of work on the part of the person with the diagnosis. And so coming to terms was incredibly important. And I was, again, incredibly thankful to be able to work with a psychiatrist, and I recognize how privileged I am in that sense, in that, you know, through medical school, I was able to ask for help from our, you know, Learner Affairs Office. And even though we have an absurdly long waitlist for psychiatric care in Canada, I was able to see a psychiatrist that I stayed with for years very, very quickly. And I recognize that that's a huge point of privilege, in my treatment in my story that a lot of other people don't have access to, whether in Canada with the publicly funded system, or the massive financial barriers that can prevent someone from receiving care and treatment. So I do like to preface my story with that. But there are a couple different components, I think the biggest most important one has been DBT, so Dialectical Behavioral Therapy. And so that was something I also was not super familiar with before I started to engage in it myself. But I found it incredibly helpful. And I guess re-examining my own thought patterns, my own emotional responses, and getting better insight to myself in that sense, and actively working on rewiring my responses to this. And, as I say, working on rewiring, that's a really important point is that, you know, I still work very hard on that. I don't think it's something that you can just, you know, go and do for six weeks and great, I am healed, no more BPD diagnosis, it's all over. It's something that, you know, at least for myself, I've had to continue working very hard at and, you know, really addressing hit on those areas of emotional dysregulation and the bad thought patterns that I can very easily fall back into. And then in addition to that, too, I am very open about the fact that, you know, I use medication. And medication is not always a great tool for people with borderline personality disorder, but for me with some other issues within the realm of mental health that I have dealt with, including depression, it's been a really important piece to my puzzle. And so I think that combination has been really important. And I have a great relationship with my psychiatrist. I think that's really important, too. And I am lucky that, you know, I see my psychiatrist for medication management, but also for therapy. And again, I know a lot of people don't have access to that. But having a good and trusting relationship with your therapist, with your psychiatrist, whoever is helping you in navigating this journey is incredibly important. And, you know, I've had therapists before, they didn't necessarily mesh well with, but I always try and tell people that I'm talking to you about, you know, my experiences, is that that's okay, it doesn't mean that therapy is, you know, not a tool that's going to work for you or not effective. Just try again, there will be someone that you'll be able to work well with. And I feel like having that relationship is incredibly important in being able to complete some of those items of therapy, and you know, be able to move on in a more productive way, learning to manage this dysregulation.

[music playing]

**BECKY EBERT**: Hi, it’s Becky Ebert, TWLOHA’s editor and producer. I want to talk to you for a moment about something specific: T-shirts. To Write Love on Her Arms has always sold t-shirts as a way to help fund our mission—the mission of hope and help. But the products we sell in our store do so much more than help us financially. Each piece of merchandise is a conversation starter. It spreads the TWLOHA message to someone who may not have found out about us otherwise. So whether you wear our shirts, hats, hoodies, or rain jackets, we want to thank you for bringing a message of hope and help wherever you go. To see our latest designs, head to store.twloha.com now and use the promo code PODCAST20 to receive 20% off your entire order.

[music playing]

**CHAD**

It’s now time for a special segment called “Pass the Mic to the Pro.” At TWLOHA, we like to think of ourselves as friends who offer you safe spaces to share your experiences and present opportunities to explore what it means to find help. But we know how important it is to bring professional voices into the conversation early on. So this is where we invite counselors, therapists, and psychologists to lend their expertise to the topic at hand.

**CHAD**

Now we’re going to be talking to a friend by the name of Patrick Miranda. Patrick is a former TWLOHA intern and is currently a licensed professional counselor. He has worked in multiple treatment settings, including residential and outpatient services for substance use disorders. Patrick has experience working with adolescents, adults, and families with a range of therapeutic issues, including addiction, mood disorders, trauma, and suicidality. He especially enjoys working with those in the LGBTQ+ community. In his downtime, Patrick reads a lot and plays an exceptional amount of video games.

**CHAD**

It is now my honor to introduce you to our friend, actually someone that has served the organization as an intern in years past, but this is our friend Patrick Miranda. For today, we're talking about borderline personality disorder. And it occurs to me that BPD among, you know, many mental health challenges is one that is so saddled with labels, with terms, with ideas more so than even symptoms and diagnoses. So can we, from the outset, just get a proper working definition for what is borderline personality disorder?

**PATRICK MIRANDA:**

Borderline personality disorder is, in my experience, one of the most stigmatized to the point where people I've worked with before clinicians, either don't want to give the diagnosis, or to tell their clients that that's what they're thinking. And so it definitely is something that and I know overall, in my life, in my experience, language really matters. But like from a clinician perspective, borderline personality disorder is a set of symptoms, right. So for borderline personality disorder we've got number one, frantic efforts to avoid real or imagined abandonment. We're going to start looking at interpersonal relationships and how that can be very difficult. Two would be a pattern of unstable and intense interpersonal relationships characterized being alternating between extremes of idealization and devaluation. Three’s identity disturbance, the official language here being markedly and persistently unstable self image or sense of self. Four impulsivity, in at least two areas that are potentially self damaging. These include money, sex, substance use, and eating. And one of the bigger ones, self injurious behaviors. There's a book titled this, like, I Hate You Don't Leave Me. That's usually where I started this idea for Borderline Personality Disorder, you have a sort of like, pushing away, and like, whoa, whoa, whoa, I didn't mean it come back.It comes back to this sort of all or nothing thinking that we touched on, when someone is either awful or the best thing ever.

**Chad**

So who does this most commonly impact who is most? If we're going to go demographically into this, who are we expecting to see arrive at a diagnosis of borderline personality disorder?

**Patrick**

You'll see a diagnosis of like three to one, women to men. I think personally, that's because we see it as a woman's diagnosis, even though like research has demonstrated that there isn't a difference gender wise. But one thing I think does happen is that you'll see this presentation of symptoms. And for men, you'll see this aggressiveness perhaps and you're like, “Oh, they're kind of oppositional, or antisocial.” And for women, people, I think, will think, tend to think more along the lines of, “oh, they're emotional.”

**Chad**

And about how many people experience or will experience BPD in their lifetime?

**Patrick**

General population at large, like 1%, we're looking at lifetime prevalency, I think, like five, to find those numbers, for sure but it's relatively small. Within a treatment center, you're looking at way higher numbers, like 20-30%. And that might be underestimating it. As clinicians, we underdiagnose this, because of some of that fear and stigma. And coming back to who does this affect, you're looking at people with, generally speaking, shitty childhoods. They had a family life and environment that was not stable, that perhaps involved a lot of mobility in their parents. And we're looking at genetics. This is similar to a substance use disorder, but like, anywhere depends on your study, like 30% to like 70% genetic.

**Chad Moses**

You hinted just a second ago about the childhood experience about the kind of the trauma link in this. And maybe this is a great time. And I think this is the first time we talked about this on the podcast, but the term of ACE, would you be able to, to kind of dip your toe into those waters as it relates to BPD?

**Patrick**

Yeah, so ACE: adverse childhood experiences. It's a sort of score that was developed, I think, someone working in an impoverished area. But since the ACE score was developed, the link between high ACE scores and health outcomes is like it's significant. The higher ACE score, the shorter your lifespan expectancy is, the more likely you are to develop physical health issues, like your blood pressure, your heart, those kinds of things. The ACE scores the things that you're looking at are what was the abuse, was it physical, was it mental, emotional abuse? What was caregiver supervision like? What was crime or violence in the social setting like? Did this person experience and then all the trauma screens that you might look at? Natural disasters, you're looking at the vehicular experiences and you're looking at any sort of violence or sexual trauma, physical, kidnapping.

**Chad**

It strikes me when you're talking about, you know, some of these ACE score metrics, these adverse situations, these are black and white, like these are objectively horrible things. Whether it's a flood, or a tornado, or a car accident, a loss of a sense of safety, a loss of a nurturing role, a loss of innocence, these are things that we rightly push back against. But we're seeing this link between these things that we did not choose, resulting in a lens through which that we're viewing the world. And where it is, if you've experienced something that is so extremely horrible, of course, you know, you, I think it's natural to try to offset some of that with things that are exceptionally great. But let's scale it back, let's look at what are the most human parts of borderline personality disorder? And before we advance, I kind of just want to break down that word “borderline.” Do you have any sense of etymology of why borderline attached disorder?

Because we are slow to change our language. We're talking like, initial DSM language here. Back when we used words like neurosis, and in fact, that's what borderline is on the, on the border of neurosis and psychosis.

**Chad**

We've talked about how BPD presents, we've talked about what goes into a diagnosis. We've talked about the who's and the what's and the whys. But let's talk about the what’s next. What does treatment look like? We know that there comes this label, as our friend Gen was saying, this understanding that this is not treatable, and we're going to go ahead and say that that's a myth that that is an untruth. So what have you Patrick seen in your research, in your experience? What does treatment look like for someone with BPD?

**Patrick**

I'm glad we're, we're moving into this. I think this is a very important part of the conversation is that kind of idea, is this curable? And yes or no. Because we do think of personality as like a stable thing, right? People will have these symptoms on a spectrum. And when we talk about from my perspective and my approach, I want to help my client better engage in their life with, like, less distress, right? I want to sort of highlight that most of my experience has been in the substance use treatment world. And so a lot of my understanding of how to approach treatment is based in that experience. And so, for me, what I've seen, especially when we're looking at, like a residential setting, consistency, consistency is one of our most important things. And that I think is also true when you're someone who is living with, you know, have a relationship with someone who is managing, struggling with borderline personality disorder and being consistent. Can we treat this? Yes, yes, we can, if you want to go look at studies and the longitudinal ones, you'll see that we're talking about remission, those rates do improve over time. People get there faster if they seek treatment, they, like, hit remission faster with treatment. And the types of treatment that we're looking at, because that's kind of my role, right, is what kinds of treatment. And I tend to be a person who looks more along the lines of cognitive based treatments. So like CBT and DBT. And in those we're looking at how someone's beliefs and values impact their thoughts as such impact emotional and behavioral responses, right? And you hit the behaviors, you hit the thoughts, and you try to like, do it all. So you can treat a person as a whole, right? But consistency is really key. People with borderline personality disorder, sometimes they come into your office and they love you. And sometimes you're someone that did these awful things. But you'll see that and being consistent, offering support, and sometimes making statements like “I understand,” or “I'm hearing you that that's really upsetting, you're really angry right now. I'm still here, I'm choosing to be in this relationship and choosing you, even if, like this thing happened, or even if we're going through this thing, like I'm still choosing you.” I think that can be really important. Those types of validation and reassurance is talking about people who really have a fear of abandonment. So I'm sorry, I've veered because my brain does that. DBT and CBT. We're looking at those thoughts and the beliefs, those distorted ones and trying to bring us more towards middle and so far, right, and we're trying to bring you somewhere closer towards a middle utilizing both rational thought and emotion to sort of adjust behavior and your responses to things, one of the things that's really difficult for people is reactivity. And so you might have this big emotion, and trying to learn how to regulate that. Or even sometimes, you're going to have it, so let's talk about how to bring your back down to level faster. Let's talk about how to communicate with other people and have those assertive communications and take responsibility for your stuff. So, we look at those thoughts, we look at the behaviors, including, how do you regulate? How do you ground yourself? What are your relaxations? What is your self care? And then, for me, my go to behavioral things for any person in my office, are you - these are like cliched right - but are you exercising? Are you sleeping? Are you eating and are you going outside? And are you hanging out with people? Right? Let's make sure that those things can happen in your life.

**Chad**

I love that about CBT and DBT. That is one thing to be mindful of your thoughts. It's another thing to peel back and say, what's driving these thoughts? Not just what am I thinking? But why am I thinking this? As we bring this in for landing, let's find a one, two or three common myths that we can dispel at this moment as it relates to borderline personality disorder/

**Patrick**

So with good supportive people in your life, I mean, things get easier. I think that's generally true for all of us. But definitely with this is like, yeah, that can get better. You're not like, screwed over for the rest of your life. It's not like you don't get to have relationships you do. You can have them right. And they can be good. So that one, like you're incurable, there's something wrong with you. It's never going to get better. That's just not right. That's not go with that one. Two, that this is a women's disorder. Also not true. Men experience the same things. And if we're talking about on a spectrum, for disorders in general like you'll see these traits if not like these extremes of them and people that doesn't like sex and gender. This is not a like picky thing like personality disorders are going to just be like only women. That's all. That's all we're gonna do. And it's not just a woman's disorder. And then three, from, I'd say, a clinician standpoint, would be that, like, it's okay to talk about, clinicians, like I said earlier sometimes won't diagnose because they don't want to, they don't want to, they don't want to have someone's record. Or they don't want to tell their client about it or talk about it with their client. And to be honest, that can be a really difficult thing. Because of reactivity and because like some labels are really hard. Some words are really hard, that that can be a very difficult conversation. But like I say it in general, for, like for my clients, if you're not aware of something, how do you fix it? If you can't think about it, if you don't know what's going on, if you can't talk about it. It's not going anywhere, right? If it's going to be something that gets better in your life. You gotta acknowledge it. And in some ways, acceptance.

[music playing]

**CHAD:** I also want to touch base on something you mentioned a little bit earlier, just and you know, maybe it's too trite to say it this way, but it strikes me as a hidden gift that you've mentioned in your blog in in this conversation, that a speed bump or a pothole in a relationship can feel when you have BPD like a tremendous grief. And at the same time, you are capable of tremendous compassion of unmatched kindness that if you feel negative emotions to an extreme, then you are also capable of incredible empathy and incredible connection to other people.

**GENEVIEVE**

I think you summed it up absolutely perfectly. And just that I definitely struggle with that middle area. And that, you know, everything's black and white and expressing, you know, just an extreme desire to be able to experience gray. And that's definitely something that you know, I struggled with a lot and so, when it comes to feeling those lows I mentioned earlier, that you know, I have struggled with depression as well, in addition to my diagnosis of BPD and that, in those periods where, you know, I go through depressive episodes, it is an unimaginable emotional pain, but also a physical pain. And it is, I can't even, you know, describe it in the way that it's just all consuming. And I really, something I've had to work really hard on is in those moments, you are blind in the sense where, you know, just like, on one of your recent podcast episodes talking about how your brain is telling you lies. And that's exactly what it is like, no, if you feel like you're never going to be out of that moment, I struggle in those moments, and in those time periods to look for the good in the future, the way out of that, that episode. And it's really scary, in a sense that even though you know, it could just be a fleeting, a fleeting moment in my life, it feels like it will never end. Thinking back to my own experiences with suicidality, and self harm, I think that all of those issues that I have struggled with are just, you know, put on full blast, and really, really intense in those times. But again, when you talk about the flip side of it, in terms of overwhelming compassion, I feel things very strongly, myself, but I also that's extended to others too. And I think that it's been an incredible tool, and being able to, you know, use that compassion with patients and my own friends and my family. And it makes me excited to do that work that I have the privilege of doing. And it's something that you mentioned earlier that I wanted to touch on, was, you know, using it, seeing it as opposed to being a negative label attached to someone in medicine, using that personal lived experience to be a better doctor, and provide care with more insight to patients who are struggling with some of those issues. I think that that's honestly, the exact way that I view things, I think my experiences have been an incredible benefit, in the sense that, you know, it gives me that insight, it allows me to provide more compassionate care, but because of the overwhelming stigma in medicine, that exists for really, any mental health struggle, it is something that's just not viewed that way by that community. In medicine, we always talk about resilience. And I've come to hate the word because of the way that it's used in medicine. And that yeah, okay, if you have struggled in the past with mental health, that's fine. Tell us how you got over it. And you know why you're a better person, and because you've had those experiences, but you can't actually express any any weakness or any current struggles, or else, you know, you're viewed as not good enough. And I know that it's a more niche population. And I'm saying for them to understand this, but going through the process of applying to residency, the same in Canada, in the States, where you're asked a lot of questions around, you know, what, what mistakes have you made that you've learned from that will make you a better doctor? What struggles or barriers have you overcome that you know, show your tenacity, show your resilience? And how will this help you in residency? It presents an image that, you know, medicine values those experiences, those lived experiences and what they can teach a person. But I learned very quickly that the questions are asked, and the appropriate answer is one that doesn't recognize failure, a way to show that you have made a failure that isn't a true failure and how you learn from it and used it to move forward or not admitting failure in any way and not admitting that you struggle in any way. And I just think it's an awful, awful disservice to all of our patients and to ourselves.

**CHAD**

I think you're right. And everything that you're saying kind of leads to another huge point in this conversation, and perhaps, in the area of all diagnosed mental health challenges that so often, we get attached to specific labels and diagnoses. And while that can provide us with a sense of guidance, and some understanding that can also for many of us, box us in or at least make us feel like we're boxed in. And another piece, the second piece that you wrote for us, is called “I Am More Than a Borderline.” And you talk about while BPD is a significant piece to the puzzle that is you that is gin that is so very far from the totality of who and what you are, you know, you wear so many hats from from wife and partner to doctor and friend and the kindness that you show to patients and just anyone else who's lucky enough to be on the receiving end. Why do you think it's important for people to respect your diagnosis, but recognize that that's not all of it, that there that's just parts to the whole of you?

**GENEVIEVE**

I think you stated it perfectly with giving us boxes that we exist within. When you depend entirely or build your view, perspective of a person entirely on that piece of information, I think that it can be incredibly limiting. And it's kind of like, you know, living with blinders on, when you view a situation and or view a person rather, in that sense with just the lens of BPD, just the lens of generalized anxiety disorder, so on, so forth. I think that you limit your own willingness to understand and get to know a person and learn their story and what makes them important and what they have to offer. But it also, I think it limits the opportunities and potentials of people with those diagnoses. If you took out all like, my family, and friends, that's a big piece of my life, if you take that out, it's not a full picture of who I am, I don't think you can understand who I am fully. But just viewing all of these things at surface level, I don't think you can also, you know, get an understanding of a person. And so, if, with a diagnosis of borderline personality disorder, for example, we talked about all of those different descriptors that are often used, and I was very afraid of when I was first diagnosed, and I bought into that same narrative when I was first diagnosed and trying to come to terms with this, with BPD in general. And I think that, as opposed to BPD being basically, you know, a prescribed narrative of what my life is going to look like, just one piece.

**CHAD**

It's almost as if, in our society, in our culture, it's common to now use people's first language that you mentioned in that blog, you are not borderline, you are someone with borderline personality disorder. And maybe one layer the onion out from that is saying you don't have BPD. But in some sense, BPD has you in that. If you don't want to be defined as this, maybe we can start defining the challenge by our friends and family that do have it. You get to be the new definition of what this is not all the stereotypes, not all the myths, not all the hurtful tags, but instead of saying, oh, BPD that means someone that X, Y and Z or I can start saying, no, that's someone that acts like my friend, Gen, that's someone that acts like my cousin, that’s someone that acts like people that I know that are real humans beyond just words on a page beyond just diagnoses. But there, there is a human element to all of these challenges. And it's that human element that we're trying to get to, these are pieces that are relatable, that there's just so many bits of you that are so much more interesting than a specific diagnosis that was given on a specific date to determine a specific set of symptoms.

**GENEVIEVE**

I really like the way that you describe that. And it brings up a really important point too, and humanizing these scary sounding conditions that we hear negative perceptions about negative statements about. And you know, just, it's sad that it is this way, but hearing from friends of mine that are also physicians, saying, oh, close friends of mine, that, you know, I've disclosed and share this with having them say, Oh, I view all of my BPD patients very differently now. Because, you know, I know you. And while that makes me happy that you know, there can be that shift in perspective somewhat, it shouldn't have to be that way. And I think that's why, you know, I want to chat with you all. And I want to share my story and my experiences, in the hopes that one day it doesn't have to be like that. Yeah, something that I find distressing quite often is, you know, when we talk about BPD, we've talked a lot about just general stigma and from healthcare providers here. But you know, when I'm looking for resources for myself, you know, to learn more about BPD, or to read on some specific topic within it. You're just inundated with books and publications of how to live with the horrible monster in your life that has BPD as opposed to, you know, being productive in any sort. But the way it's presented, you know, it's villainized from the very start and it, in trying to teach the public and people who have someone in their lives with BPD how to, you know, approach these relationships and how to work on them. It villainizes the person with BPD right from the very start. And so I think that that narrative in general, it needs to change, because education is really just the only way that these viewpoints shift. And I'm thankful that you know, with my generation of physicians and my generation in society, just in general, on average, it seems like people are more willing to have these conversations, and willing to address these problematic viewpoints and ways of thinking. But there are so many areas this needs to start with to really just rewrite the culture, as opposed to placing that individual blame on someone with a diagnosis that they didn't choose with experiences that led to this diagnosis that they didn't choose and that they want to manage.

**CHAD**

Well, in that same spirit then to bring this into a close, if we were to imaginatively pass the baton to more people in our state to more people in our generation, maybe even the people younger than us that we can imagine, are facing the same questions that you had. What would you say to someone listening right now who struggled with BPD? What are any sort of guiding words or mantras that have been gifted to you or that you've discovered through this journey that that you would wish to express to other people?

**GENEVIEVE**

I think, you know, first and foremost, tomorrow is waiting for you, and you deserve tomorrow. And I think that, you know, in re-framing your own thoughts about BPD, and what that means and what that is to you, I think that it needs to involve some form of hope. And you know, what, that's what tomorrow is.

[music playing]

**CHAD**: Our sincerest thanks go out to Genevieve Jacobs for her bravery and willingness to share her journey with BPD, and to Patrick Miranda for helping us better understand the symptoms, treatment, and care.

And to you, the listener, we’re so grateful for your time and attention. These conversations matter and knowing you’re tuning in is what makes them exceptionally special and powerful. Thank you for choosing to listen. We’re glad you’re here.

[music playing]

**CHAD**: We hope this episode has been a reminder that your story is important, you matter, and you’re not alone.

If you’re struggling right now, know that it is OK to reach out and that there are people who want to help. Part of our mission is to connect people to the help they need and deserve. You can find local mental health resources on our website [twloha.com](http://twloha.com/). That’s [T-W-L-O-H-A.com](http://t-w-l-o-h-a.com/). And Click FIND HELP at the top of the page.

If you need to talk to someone right now, you can always text our friends at Crisis Text Line. Simply text the word TWLOHA—that’s T W L O H A—to 741741. You’ll be connected to a crisis counselor. It’s free, confidential, and available 24/7.

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A big thank you to our friends at Copeland for the original music on this episode. The To Write Love on Her Arms podcast is produced by Rebecca Ebert. Music assistance was provided by James Likeness and Ben Tichenor. And again, I'm Chad Moses, thank you so much for listening. We’re glad you’re here.