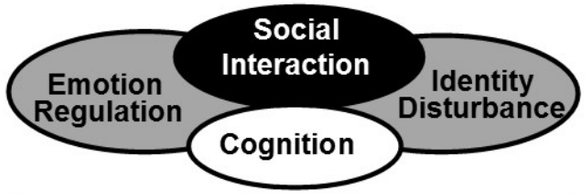
WHAT IS PERSONALITY DISORDER?

Personality: Individual differences in characteristics patterns of thinking, feeling and behaving affecting relationships to others. **Personality Disorder:** Inflexible rigid, patterns of thinking, functioning and behaving. The person has trouble perceiving and relating to situations and people, is not able to deal with people or problems constructively, to adapt to changing demands of the environment. These traits can significantly impair a person's ability to function.

BORDERLINE PERSONALITY DISORDER

A genetically based severe and chronic mental illness characterized by a persistent emotional instability, rapid mood changes, problems sustaining relationships, uncertain self-image, impulsive behaviors, self-injurious behaviors, and frequent suicide threats or attempts. Emotions experienced intensely. Extreme sensitivity to sensory stimuli. Maladaptive means are used to cope with constant emotional pain. BPD is diagnosable in children and adolescents.



Diagnosis: At least 5 of the following

1. Frantic efforts to avoid real or imagined abandonment.
2. Unstable, intense stormy interpersonal relationships, alternating extremes of idealization and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image and sense of self, shifting from feeling confident about self to feeling incompetent and bad.
4. Impulsivity in two potentially self-damaging areas or behaviors leading to serious consequences.
5. Recurrent suicidal thoughts, behavior, gestures, threat and attempts, or self-injurious behavior such as cutting/burning.
6. Intense emotional instability, rapidly changing short-term moods and anxiety (usually lasting a few hours, rarely more than a few days).
7. Chronic feelings of emptiness, sadness.
8. Intense inappropriate anger or difficulty controlling anger.
9. Transient, stress related, paranoid ideation, severe dissociative symptoms, feeling as if losing touch with reality.

DIAGNOSING BPD

- BPD is most often misdiagnosed
- Usually receive 5+ diagnoses before BPD diagnosis given over course of 10 years
- ADHD, Depression, Anxiety, bipolar disorder, eating disorders, substance abuse, CD, IED, ODD
- Diagnosis most often made without reliable clinical diagnostic testing.
- Diagnosis of those under 18 is generally avoided

BPD FACTS

- 5.9% of the general population
- 11% mental health outpatients
- 20% of inpatient psychiatric population
- 6% of primary care patients
- Highest users of ER services.
- Most intensive and extensive utilizers of mental health services.
- 53% unemployed, 39% on disability

BPD AND ADDICTIONS

- 38% of people with BPD have a substance abuse disorder
- 78% of BPD adults develop a substance-related disorder
- 67% of substance abusers and mental illness *(Carlos Grilo)*
- 74% of alcoholics meet BPD criteria
- 44% of opiate addicts (Sansone, R)
- 50-67% of MICA (mental ill/chem abusers)
- 54% nicotine dependence
- 16% of problem gamblers
- 26% of compulsive shoppers

BPD plus addiction requires a special therapeutic approach. Substance Abuse Treatment that does not treat BPD is bound to fail.

BPD AND SUICIDE

- 80% have suicidal behavior
- 70% attempt suicide
- 10% die by suicide
- Suicide rate is 400x national average
- People with BPD do not wish to die, they attempt suicide to escape emotional pain

TARA 4 BPD

How TARA4BPD Helps

We raise awareness of BPD with lectures and symposiums at professional conferences, advocate with legislators, mental health systems and policy makers, provide information and treatment referral by request, conduct workshops for people with BPD and their families, alert cutting-edge researchers to family and patient experiences.

HELPLINE & REFERRALS
1-888-4-TARABPD
212-966-6514

- ◊ **8 Week Family Survival Skills Workshop**
- ◊ **3 Day Family Weekend Workshops**
- ◊ **Get the FACTS, Living with BPD**
- ◊ **BPD Psychoeducation for People with BPD**
- ◊ **Crisis Clinic for Family Members**
- ◊ **Graduates or family member in need of help**
- ◊ **Mentalization Workshop**

JOIN TARA NOW and DONATE

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Credit card_____CVV_____.

EXP_____Join/Donate_____Amount_____

Donation _____

Individual $75 Family/Prof $100 Make checks payable to TARA4BPD, 501(C)3 nonprofit org **All Contributions are lawfully tax deductible.**

TARA 4 BPD

Borderline Personality Disorder

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BPD CO-OCCURING DISORDERS

- 85% lifetime prevalence for comorbidities
- 49% have an impulse-control disorder, most intermittent explosive disorder
- 61% have an anxiety disorder (specific phobia, social phobia)
- 20% have bipolar disorder
- 23%-40% of people with eating disorders also have BPD.
- 30% of chronic pain patients have BPD
- Immune Disorders: 26% have fibromyalgia
- Chronic Fatigue 11%, IBS 6%
- 22% afflicted with HIV

BPD worsens the outcome and complicates the treatment of any co-occurring disorder

BPD AND THE LAW

- 45% of prison inmates (42% male, 52% female)
- 1/3 of male batterers.
- 1/3 of stalkers
- 25% of self-reported road rage perpetrators
- Male BPDs incarcerated for violence

Untreated and Misdiagnosed BPD has created a MAJOR PUBLIC HEALTH CRISIS.

BPD NEUROSCIENCE RESEARCH

- Brain connectivity irregularities
- Heightened limbic reactivity to social cues
- Hyperreactive threat perception system
- Overresponsive amygdala
- Exaggerated fight or flight response
- Difficulty naming what they are feeling
- Alexithymia: Heightened insula reactivity
- Negatively biased perceptions
- Heightened rejection sensitivity
- Heightened self-referential processing
- Identity diffusion: Unrealistic representation of self and others
- Heightened sense of shame
- Anger & Impulsive aggression
- Affective instability
- Relationship disturbances
- Anomalous pain processing
- Top down Prefrontal cortex connectivity
- Irregularities in opioid system
- Irregularities in oxytocin system
- Difficulty trusting others

SHAME: THE COMMON DENOMINATOR OF BPD REACTIONS

BPD STIGMAS & MISCONCEPTIONS

BPD is the most stigmatized of all mental disorders. Many clinicians will not treat any BPD patients, seeing them as the most difficult patient, treatment resistant, manipulators and liars, and as just wanting attention. They are considered a "liability" due to increased risk of self-injurious and suicidal behavior, presumed to never get better. BPD patients replaced schizophrenics in psychiatry's treatment revolving door.

According to *Dr. Dvoskin* ,ex Comm. Of the NYS Office Of MH, "Why would psychiatry and psychology turn so viciously against people they call mentally disordered? Apparently the greatest sin a client can commit is poor response, they have yet to demonstrate the ability to get better in response to our treatment. Thus, they don't make us feel very good. With a few notable exceptions, we have simply given up on helping people who desperately need us to do a better job of helping them."

Parents of those with BPD have taken the place of "schizophrenogenic" and "ice-box mothers" of autistic children as the family blamed for psychiatric illness. They are viewed as causing BPD due to failure to attach, abusing, neglecting or invalidation the person These conclusions are based on patient "self-report", the very people suffering with alexithymia and the perceptual biases, symptomatic of BPD. BPD is extremely painful to the patients, to those who live with them and to society.

BPD TREATMENT

DIALECTICAL BEHAVIOR THERAPY

Developed by Marsha Linehan, is a behavioral EBT based on dialectics; opposites can coexist and be integrated, both points of view are valid. DBT focuses on balancing change with acceptance; aims to replace maladaptive coping methods with more effective means of achieving goals. It teaches skills to help the person get what they want or need. DBT skill training includes mindfulness and modules on distress tolerance, emotional regulation and interpersonal relationships. It aims to help the person develop a life worth living. DBT is an outpatient treatment: once weekly individual psychotherapy, two-hour weekly psychoeducation skills groups, therapist consultation meetings, and availability of the therapist for phone coaching. DBT was not de signed as an inpatient treatment.

MENTALIZATION

Developed by Bateman and Fonegy, it is an EBT focusing on how to make sense of our own actions, behaviors and feelings and those of others. It explores relationship ruptures, develops empathic understanding, examines misunderstanding the intentions of others resulting in difficulties with relationships, especially with those closest to the person (attachment relationships) It teaches people to be aware of how they and others are thinking and feeling **in the moment**, and how what we think and feel can trigger intense reactions.

TRANSFERENCE FOCUSED THERAPY

Developed by Otto Kernberg, TFP is an intensive manualized outpatient EBT psychodynamic psychotherapy. The goals of TFP are to develop better behavioral control, increase affect regulation, develop more intimate gratifying relationships, and to achieve satisfactory life goals. It aims to reduce suicidality, self-injurious behavior, impulsivity and anger and to decrease ER visits, hospitalizations, and relationship difficulties. It is a lengthy treatment requiring 2-4 weekly sessions.

MEDICATION

Unfortunately, there is no single "one-size-fits-all" medication for BPD. Medications may reduce symptoms although results are not usually long lasting. People with BPD are generally over-medicated and prone to addiction. Benzodiazepines should not be prescribed (Valium, klonapin, Xanax, Ativan).

COMPASSION FOCUSED THERAPY

Developed by Paul Gilbert, it integrates cognitive behavioral therapy, evolutionary psychology, social and developmental psychology, Buddhist principles, & neuroscience. It uses compassionate mind training to help develop experiences of inner warmth, safeness and soothing, via compassion & self-compassion. CFT is especially helpful for those with high levels of shame and self-criticism and have difficulty feeling warmth toward, being kind to themselves or others.

SCHEMA THERAPY

Developed by J. Young, it integrates elements of cognitive therapy, behavior therapy, object relations, and gestalt therapy. It helps change enduring negative ("maladaptive") & self-defeating patterns or schema a person has lived with for a long time. The targeted schemas typically begin early in life.

WHY DO SOME DEVELOP BPD?

Latest research indicates BPD is a biologically based disorder with a major genetic component (Heritability 74% Torgerson). Biological "vulnerabilities" place a person at risk. They are generally hypersensitive to sensory stimuli (noise, odors & textures), are either **hyper/hyporesponsive** to pain, have difficulty sleeping, often beginning in childhood. They have memory deficits, often exaggerating negative events. Difficulty labeling what they feel leads to frequent misdiagnosis. They also suffer from autoimmune disorders.

HOW FAMILIES CAN HELP

With understanding and training, family members can become part of the solution, rather than part of the problem. As theyplay an integral part in helping , they must learn all about BPD. The TARA Method, described in *Overcoming Borderline Personality Disorder: A Family Guide for Healing and Change* by Valerie Porr, offers evidence-based methods to improve and repair relationships, decrease frequency and intensity of escalations while reinforcing adaptive coping. **With compassion,** educated family members can avoid suicide threats and attempts. Families can advocate for appropriate BPD treatment and increased research funding.

START A TARA AFFILIATE
ORGANIZE A TARA FAMILY WORKSHOP
ADVOCATE LOCALLY & NATIONALLY