

A Supplemental Take-Home Module
for the
NAMI Family to Family
Education Program

BORDERLINE
PERSONALITY
DISORDER

Prepared in cooperation with
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BORDERLINE PERSONALITY DISORDER

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Borderline Personality Disorder: The Basics You Need to Know

Borderline Personality Disorder (BPD) is an often misunderstood condition that has many challenging aspects and good treatment options. BPD is often characterized by intense and stormy relationships, problems with self image, self injurious acts, mood fluctuations, and impulsivity. The hallmark of BPD is emotional dysregulation. All of these symptoms cause difficulty in work and personal relationships. BPD is estimated to impact about 4-6 million Americans with more females diagnosed than males by a ratio of about 3:1. New research and treatment ideas have improved the outlook for people living with BPD and their families.

What is in a name?

The term borderline isn't very helpful - referring to previous thinking about the condition, BPD used to be considered on the 'borderline' between psychosis and neurosis. The name prevailed even though it doesn't describe the condition very well and, in fact, may be more harmful than helpful. The term 'borderline' also has a history of misuse and prejudice. BPD is a clinical diagnosis, not a judgment.

A more modern way of thinking about the condition focuses on ongoing patterns of difficulty with self-regulation that lead to troubles with emotions, thinking, behaviors, relationships, and self-image.

Is BPD a serious mental illness?

BPD is a serious mental illness that can cause a lot of suffering, carries a risk of suicide, and one that requires good assessment and treatment. It was defined by the American Psychiatric Association (APA) in 1980 - so it is a relative newcomer to the psychiatric world. In most aspects it is 20 years behind other psychiatric disorders in such areas as research, medication, and family support

BPD is currently classified by the APA as a personality disorder. A personality is a cluster of traits unique to each person that determine how one relates to oneself, other people, and the world in general. A personality disorder is a regular pattern of relating to oneself and others that is troubled. People with BPD have been shown to have brain changes in imaging studies, proof that there is a biological component to the disorder. Some experts believe the condition is not a personality disorder and should be classified as a major mental illness like bipolar disorder. However it is now classified as a personality disorder. There is a lot known and a lot more to learn about BPD.

Why would a person cut one's self or repeatedly perform self defeating, impulsive acts?

It can be difficult to imagine being in the shoes of a person with BPD if you do not have the condition, but these are actual symptoms of the disorder. Cutting and other self

injurious behaviors are scary and often difficult to understand. This way of dealing with overwhelming feelings, such as cutting, may have biological roots - research suggests a release of endorphins - pleasure chemicals naturally found in the brain. Substituting alternate coping strategies for cutting is a key part of the treatment. Additionally, fear of abandonment and a tendency to overvalue and devalue others are components of the disorder as well. Combined with impulsive behavior and problems with anger, these characteristics lead to stormy relationships. Fortunately, many sufferers are able to recognize these patterns in themselves, develop strategies to cope with them, and improve over time.

How big of a risk is suicide?

Suicide is a real concern for the condition. Overall, the total percentage of people who kill themselves with BPD is about 9 to 10%. Many factors make this risk more likely however. For example, the risk increases for people with BPD who also have alcohol or drug problems who do not get needed treatment. Treatments like Dialectical Behavior Therapy (DBT) can reduce the risk.

What is the course of the condition?

The course of BPD depends on many factors. Research has shown that the course can be quite good for people with BPD, particularly if they are engaged in treatment. Often the teens and early twenties are the hardest, with hospitalizations and self injury crises common. Doing the work and learning about the condition and ways to manage the symptoms pays benefits. Research has shown that many people improve over time. In this way BPD is a high risk condition but may also have a good prognosis.

How can families deal with such unpredictable and difficult behavior?

BPD is challenging to live with for the person who has it, and also for families and loved ones. Strong emotions and poor impulses can adversely affect loved ones. Relationships are important to help people with BPD - but the disorder often taxes personal connections. People in relationships with people with BPD need strategies and support also. Fortunately, there are good resources and programs to support people involved with this problem. The National Education Alliance on Borderline Personality Disorder (NEA-BPD) has the Family Connections program designed for exactly this need. NAMI's signature program Family to Family can also offer knowledge and support. There are also excellent books and web sites that provide resources to help families think about how best to support their loved one and themselves when living with someone who has BPD

Is abuse always part of the picture with BPD?

No. There are, however, events that may occur in the environment that play a role in the development of the disorder. The most severe may be various forms of abuse including emotional, physical, and sexual abuse. Loss and neglect may also be contributing factors.

However, some people develop BPD with no history of abuse at all. The best thinking at this time is that there are people who have a higher biological or genetic vulnerability to this condition, and abuse can compound this risk to produce the disorder. But the people living with BPD who have no history of abuse also show that there is a very strong biological component to the condition. The current emphasis of many treatments is to focus on the present day realities and strategies to cope while respecting the role of the past in the person's life.

Is there a blood test to help with the diagnosis?

No. There are no blood tests, or imaging studies (like CAT scans) that are useful to help make the diagnosis. Brain imaging is helping to understand the condition and more brain research is needed. The condition is a clinical diagnosis - there are certain patterns of behaviors and experiences that make the diagnosis. These are the current diagnostic criteria for the American Psychiatric Association:

A pervasive pattern of instability of interpersonal relationships, self image and affects, and marked impulsivity beginning in early adulthood and presenting in a variety of contexts as indicated by 5 or more of the following:

- 1) frantic efforts to avoid real or imagined abandonment
- 2) a pattern of unstable and intense interpersonal relationships
- 3) identity disturbance
- 4) impulsivity in at least two areas that are self damaging
- 5) recurrent suicidal behavior gestures, threats, or self mutilating behavior
- 6) affective instability
- 7) chronic feelings of emptiness
- 8) inappropriate, intense anger
- 9) transient stress related paranoid ideation or severe dissociative symptoms

These criteria are being reviewed for the next version of the APA's Diagnostic and Statistical Manual (DSM) which is currently projected to be published in 2012.

Are all people with BPD the same?

No. While the symptom picture is often similar, every person has unique strengths, a specific relationship to their family and friends, and may have other psychiatric and medical conditions that complicate the condition. For instance, people with BPD often have challenges with one or more of the following as well: depression, bipolar illness, eating disorders, anxiety, post traumatic symptoms, and substance abuse. One person with BPD may be able to work well, while another struggles as an employee. It takes a complete assessment to put a good treatment plan in place that addresses the person's strengths and vulnerabilities.

Why can't my sister see she has BPD? She meets all the criteria!

Many people with BPD can't see their own role in the storms of their lives. Difficulty tolerating strong feelings and a deep sense of shame can make people transfer their problems onto other people. The blaming that can result can be very stressful and alienating. In some ways the lack of insight for people with BPD is similar to that same deficit in other major mental illnesses like schizophrenia. Some people learn to accept their role in their turbulent lives over time, often aided by treatment. Family education programs, specific web sites, and resource reading materials help address the concerns of those who love and care for those persons demonstrating the symptoms.

What types of treatment are there for people with BPD?

A good plan for an individual will likely have several components selected from a menu of interventions - talk therapy, skills training, group work, peer support, family education, work/school support, medications, and issue specific groups like AA. A good plan needs to be designed one person at a time based on their particular concerns. There is no "one size fits all" treatment for persons living with BPD.

Skills Training - /Dialectical Behavioral Therapy

Dialectical behavioral therapy (DBT) is a relatively recent treatment, developed by Marsha M. Linehan PhD, in the 1980s. DBT has several important goals: mindfulness, emotion regulation, interpersonal effectiveness, and distress tolerance. The teaching and development of skills the individual can use on his/her own to manage strong feelings are central components of DBT. The treatment uses group sessions, individual therapy, and homework with telephone coaching - but the hard work often pays off. For example, DBT reduces the risk of suicide, anger, number of days in the hospital, and in general, helps many people function better in relationships. DBT is the best studied intervention for BPD at this time.

DBT offers clear options for self care, alternatives to self destructive acts, and new ways to understand one's behavior. It is also difficult to get - there is a shortage of professionals who are trained in this modality, and insurance may or may not pay for it. Advocating for your local service center to have practitioners trained in DBT is an important advocacy strategy.

Psychotherapy

A therapeutic relationship with a knowledgeable and compassionate professional can offer real help to people with BPD (see Eileen White's experience in box A). There are many branches of psychotherapy that are useful for BPD - they typically have in common several features - the centrality of a clinical alliance, a focus on relationships (including the relationship with the therapist), developing alternatives to self destructive behaviors, and a safe place for a person to take their concerns and learn new behaviors. For many people, a good psychotherapy relationship can make all the difference.

Cognitive Behavioral Therapy (CBT) is focused on evaluating and changing a person's thinking, which often drives a person's experience. This can be a useful way to address depression and anxiety as well - conditions that often occur with BPD.

Peer Support

Learning from someone who has 'been there' can be a very useful tool. When someone has managed to get control of their symptoms of BPD, and develop alternative behaviors and strategies, he or she can become models for hope and learning. Peer support can be helpful in reducing shame and isolation that often occur with the condition. This is not a substitute for professional support but can be an important adjunct for people with BPD. See Middle Path, NAMI's Peer to Peer and NAMI Cares below. Some people use online forums for and by people with BPD to add to their treatment.

Family Education

Living with a person who has BPD can be exhausting and difficult without help. As people with BPD are very sensitive to their relationships and environment, improving family support can assist all concerned. There are strategies that families can use to help themselves and support the person who has BPD. See below for a list of good resources.

Medications

While medicines can be a very important part of helping people with BPD, there is no single medicine to treat the condition. Medications can address symptoms that occur with BPD - and that can help therapy be more effective. Studies have shown that medicines and therapy together often show improvement for people with BPD. The selection of a medicine depends on the needs of the individual. For instance, antidepressants can help with symptoms of depression and anxiety. Antipsychotic medications can help with distortions of reality, help to organize thinking, and reduce paranoia if that is a concern. Impulse control medicines may help with this important area of concern for people with BPD. This is a very individual choice, and these elements of care should be discussed in detail with a qualified practitioner. All medicines have risks and benefits and the task is to find help with the fewest possible side effects.

How do I select a professional for treatment?

Finding a good fit with a professional is a very important piece of the puzzle. As there is a shortage of caregivers for the condition, it can be a difficult task in some parts of the country.

Some questions to consider:

Do you have experience working with people who have BPD?

Do you have training in DBT or other psychotherapy that may help me?

Do you have the support you need to help me?

BORDERLINE PERSONALITY DISORDER:

Borderline personality disorder (BPD) is a devastating mental illness that centers on the inability to manage emotions effectively. The symptoms include impulsivity, mood lability, rage, bodily self harm, suicide, chaotic relationships, fears of abandonment and substance abuse. Officially recognized in 1980 by the psychiatric community, BPD is at least two decades behind in research, treatment options, and family education compared to other major mental illnesses.

While some persons with BPD are high functioning in certain settings, their private lives may be in turmoil. Others are unable to work and require financial support. The high prevalence of BPD and its high personal, social, and economic toll make it a national public health burden.

Prevalence in Adults

- 4 million American individuals have BPD (~ 2% of general public)*
- BPD is more common than schizophrenia
- 20% of psychiatric hospital admissions have BPD (more than for major depression)
*5.9% prevalence in survey of 34,635 adult interviews by NIAAA, NIH, published March 2008, Journal of Clinical Psychiatry

Suicide and Self Injury in Adults

- 10% of adults with BPD commit suicide
- a person with BPD has a suicide rate 400 times greater than the general public
- a young woman with BPD has a suicide rate 800 times greater than the general public
- 55-85% of adults with BPD self-injure their bodies

Prevalence and Suicide in Youth

- 33% of youth who commit suicide have features of BPD

Treatment Challenges

- no FDA-approved medication exists for BPD
- BPD can co-occur with other illnesses (e.g., 60% also have major depression)
- research-based therapies for BPD are not widely available
- a 30-yr-old woman with BPD typically has the medical profile of a woman in her 60s

Economic Impacts

- up to 40% of high users of mental health services have BPD
- over 50% of individuals are severely impaired in employability
- 12% of men and 28% of women in prison have BPD

February 2008

Source: Research presentations of NEA-BPD conferences 2002-2007



National Education Alliance for Borderline Personality Disorder

WHAT IS NEA-BPD?

NEA-BPD is a non-profit 501c(3) organization whose mission is to raise public awareness, provide education, promote research on borderline personality disorder, and enhance the quality of life of those affected by this serious mental illness.

NEA-BPD offers an international website, supported, in part, by the National Institute of Mental Health, where the most current information and research is available including video streaming of conferences devoted to this challenging disorder. NAMI invites you to visit the NEA-BPD website for further information on the organization and to learn about the availability of a family program with a focus on BPD.

NEA-BPD GOALS

- Lead family education programs including teleconferencing
- Host conferences for families, professionals, sufferers
- Conduct family research
- Publish books, articles and pamphlets
- Produce informational video-tapes

RECOGNIZING BPD

Borderline Personality Disorder (BPD) is a serious, but very treatable, mental illness characterized by pervasive instability in moods, interpersonal relationships, self-image, and self-harm.

Symptoms include:

- ▲ frantic fears of real or imagined abandonment
- ▲ pattern of unstable and intense interpersonal relationships
- ▲ markedly and persistently unstable self-image or sense of self
- ▲ impulsivity in at least two areas that are potentially self-damaging
- ▲ recurrent suicidal behavior, threats, or self-harming behavior
- ▲ affective instability due to a marked reactivity of mood
- ▲ chronic feelings of emptiness
- ▲ inappropriate, intense anger or difficulty controlling anger.

©FAMILY CONNECTIONS and ©TELE-CONNECTIONS

to provide the foundation for a better understanding of this complex disorder

***12-week Program *Education *Skills *Resources *Support**

The instability created by the symptoms often disrupt family and work life and while less known than schizophrenia or bipolar disorder, BPD is more common, affecting 2% of adolescents and adults.

The ©Family Connections and ©Tele-Connections programs are designed specifically to help family members and friends obtain knowledge and develop and practice skills in an open and supportive forum for discussion that will be helpful to them for their own well being and to build a support network with other individuals with a relative with borderline personality disorder (BPD).

Group leaders, who are family members themselves, have extensive personal experience in this area and have committed themselves to the training needed to disseminate and maintain the integrity of the program content.

FOR INFORMATION

Please contact by E-mail: NEABPD@aol.com

or mail to:

NEA-BPD, P.O Box, 974 Rye, New York 10580

COURSE CONTENT

Series offers

- Education on borderline personality disorder (BPD)
- Research on BPD
- Skills training based on Dialectical Behavior Therapy (DBT) in the context of a supportive group environment
- Application and practice of skills
- Development of a support network

Topics addressed

- ✓ Education on BPD
- ✓ Research on BPD
- ✓ Family Perspectives and Experiences
- ✓ Relationship Mindfulness Skills
- ✓ Family Environment Skills
- ✓ Effective Communication Skills
- ✓ Validation Skills
- ✓ Problem Management Skills

Please see www.borderlinepersonalitydisorder.com for more information and video viewing

A BPD BRIEF

An Introduction to Borderline Personality Disorder

*Diagnosis, Origins, Course,
and Treatment*

by

John G. Gunderson, M.D.

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Borderline Personality Disorder Diagnosis *DSM-IV-TR Diagnostic Criteria

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- (1) Frantic efforts to avoid real or imagined abandonment.
Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.
- (2) A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
- (3) Identity disturbance: markedly and persistently unstable self-image or sense of self.
- (4) Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating).
Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.
- (5) Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
- (6) Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
- (7) Chronic feelings of emptiness.
- (8) Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
- (9) Transient, stress-related paranoid ideation or severe dissociative symptoms.

* *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association

Overview of the Borderline Personality Disorder Diagnosis

Every person has a personality: longstanding ways of perceiving, relating to, and thinking about the environment and oneself. However, when these traits are inflexible, maladaptive, and cause significant functional impairment or subjective distress, they constitute a *personality disorder*.

There are 11 classified personality disorders and of those, Borderline Personality Disorder (BPD) is the most common, most complex, and one of the most devastating, with up to 10% of those diagnosed committing suicide. BPD patients constitute approximately 1-2% of the general population, up to 20% of all psychiatric inpatients and 15% of all outpatients. Three-fourths of patients diagnosed with BPD are female.

Diagnosis of BPD can often escape identification because the disorder frequently co-occurs with other conditions such as depression, bipolar disorder, substance abuse, anxiety disorders, and eating disorders.

There are also many ways people experience the disorder since only five of the nine criteria of BPD (See page 2) qualify a person for the diagnosis. Additionally, people experience many fluctuations in their symptoms.

As a result of clinical observations since the 1930's and scientific studies done in the 1970's, psychiatrists determined that people characterized by intense emotions, self-destructive acts, and stormy interpersonal relationships constituted a type of *personality disorder*. The term "Borderline" was used because these patients were originally thought to exist as atypical ("borderline") variants of other diagnoses and also because these patients tested the borders of whatever limits were set upon them. The diagnosis became "official" in 1980. While there has been much progress in the past 25 years in understanding and treating BPD, the term "borderline" has often stood in the way of reaping these benefits due to its negative associations. This owes mainly to the fact that symptoms of BPD make patients difficult to treat and often evoke feelings of anger and frustration in the people trying to help. Such negative associations have made diagnosing BPD problematic, with many professionals often unwilling to make the diagnosis. This problem has been aggravated by the lack of appropriate coverage for the extended psychosocial treatments that BPD usually requires.

It is important to recognize that the BPD diagnosis is a means of explaining a set of symptoms causing trouble in a person's life. Since the symptoms involve ways of perceiving and interacting with oneself and the world, they are considered part of a "personality disorder." However, the BPD diagnosis is not a judgment on the person.

An Explanation of the DSM-IV TR Criteria

As mentioned earlier, for a patient to be diagnosed with Borderline Personality Disorder, he or she must experience 5 out of the 9 criteria as set forth in the DSM-IV TR. Here is a more detailed explanation of these symptoms:

- 1. Abandonment Fears.** These fears should be distinguished from the more common and less severe phenomena of separation anxiety. The perception of impending separation or rejection, or the loss of external structure, can lead to profound changes in the BPD patient's self-image, affect, cognition, and behavior. Individuals with BPD are very sensitive to environmental circumstances, and may experience intense abandonment fears and inappropriate anger even when faced with a realistic time-limited separation or when there are unavoidable changes in plans. They may believe that this abandonment implies they are "bad." These abandonment fears are related to an intolerance of being alone and a need to have other people with them. Frantic efforts to avoid abandonment may include impulsive actions such as self-injurious or suicidal behaviors. It was originally postulated that fear of abandonment developed as a result of failures in a child's development during the rapprochement phase (from ages one-and-a-half to two-and-a-half). However, empirical evidence has not borne this out. Fear of abandonment is now commonly thought to be a symptom of early insecure attachment, and it may have a heritable component.
- 2. Unstable, Intense Relationships.** Individuals with BPD are frequently unable to see significant others (i.e., potential sources of care or protection) as other than idealized (if gratifying), or devalued (if not gratifying). This is often referred to as "black and white thinking," and in psychological terms, reflects the construct of "splitting." When anger initially intended towards a loved one is experienced as dangerous, it gets "split" off to preserve the loved one's goodness. Relationship instability is also influenced by other BPD symptoms, such as a patient's difficulty in regulating emotional states and managing impulses, his or her difficulty being alone, and the fear of rejection.
- 3. Identity Disturbance.** The disorder of self which is specific to borderline patients is characterized by issues regarding an unstable self-image or by experiencing no discrete identity. Borderline patients often have values, habits, and attitudes which are dominated by whomever they are with. The interpersonal context in which these identity problems get magnified is thought to begin with not learning to identify one's feeling states and the motives behind one's behaviors.

4. **Impulsivity.** The impulsivity of the borderline individual is frequently self-damaging, in its effects if not in its intentions. This differs from impulsivity found in other disorders such as manic/hypomanic or antisocial disorders. Common forms of impulsive behavior for borderline patients are substance or alcohol abuse, bulimia, promiscuity, and reckless driving.
5. **Suicidal or Self-injurious Behaviors.** Recurrent suicidal attempts, gestures, threats, or self-injurious behaviors are the hallmark of the borderline patient. The criterion is so prototypical of persons with BPD that the diagnosis rightly comes to mind whenever recurrent self-destructive behaviors are encountered. Self-destructive acts often start in early adolescence and are usually precipitated by threats of separation or rejection or by expectations that the BPD patient assume unwanted responsibilities. The presence of this pattern assists the diagnosis of concurrent BPD in patients whose presenting symptoms are depression or anxiety.
6. **Affective Instability.** Early clinical observers noted the intensity, volatility, and range of the borderline patient's emotions. It was originally proposed that borderline emotional instability involved the same problems of affective irregularity found in persons with mood disorders, particularly depression and bipolar disorder. It is now known that although individuals with BPD display marked affective instability (i.e., intense episodic depression, unrest, anger, panic, or despair), these mood changes usually last only a few hours, and that the underlying dysphoric mood is rarely relieved by periods of well-being or satisfaction. These episodes may reflect the individual's extreme reactivity to stresses, particularly interpersonal ones.
7. **Emptiness.** Chronic feelings of emptiness, described as a visceral feeling, usually felt in the abdomen or chest, plague the borderline patient. It is not boredom, in the commonly understood sense of that word. Nor is it a feeling of existential anguish. This feeling state is associated with loneliness and neediness. BPD patients use words such as "nothingness," "hollowness," "no feelings, no thoughts, no dreams" to describe their experience.
8. **Anger.** The anger of the borderline patient may be due to temperamental excess or to the infant's response to excessive frustration. Whether the cause is genetic or environmental, many individuals with BPD report feeling angry much of the time, even when the anger is not expressed overtly. Anger may be elicited when an intimate or caregiver is seen as neglectful, withholding, uncaring, or abandoning. Expressions of anger are often followed by shame and guilt, and contribute to a feeling of being evil.
9. **Lapses in Reality Testing.** Borderline patients can experience dissociation symptoms: feeling unreal or that the world is unreal. These symptoms are associated with other disorders, such as schizophrenia and Post Traumatic Stress Disorder (PTSD), but in those with BPD the symptoms generally are of short duration, at most, a few days, and often occur during situations of extreme stress. Borderline patients also can be unrealistically self-conscious, believing that others are critically looking at or talking about them. These lapses of reality in the BPD patient may also be distinguished from other pathologies in that generally the ability to correct their distortions of reality with feedback remains intact.

The borderline traits are generally subdivided into three factors, each of which represents an underlying temperament (*aka* "phenotype"):

1. Affect dysregulation (criteria 6 and 8)
2. Impulsivity (criteria 4 and 5)
3. Disturbed attachments (criteria 1, 2, and 6)

The Origins of BPD

Borderline Personality Disorder, like all other major psychiatric disorders, is caused by a complex combination of genetic, social, and psychological factors. All modern theories now agree that multiple causes must interact with one another in order for the disorder to become manifest.

There are, however, known risk factors for the development of BPD. The risk factors include those present at birth, called temperaments; experiences occurring in childhood; and sustained environmental influences.

A. Inborn Biogenetic Temperaments

The degree to which Borderline Personality Disorder is caused by inborn factors called the “level of heritability” is estimated to be 68%. This is about the same as for bipolar disorder. What is believed to be inherited is not the disorder, per se, but the biogenetic dispositions, i.e. temperaments (or as noted above, phenotypes). Specifically, BPD can develop only in those children who are born with one or more of the three temperaments noted above: Affective Dysregulation, Impulsivity, and Disturbed Attachments. Such temperaments represent an individual’s predisposition to emotionality, impulsivity, or relationship problems. For children with these temperaments, environmental factors can then significantly delimit or exacerbate these inborn traits.

Many studies have shown that disorders of emotional regulation or impulsivity are disproportionately higher in relatives of BPD patients. The affect/emotion temperament predisposes individuals to being easily upset, angry, depressed, and anxious. The impulsivity temperament predisposes individuals to act without thinking of the consequences, or even to purposefully seek dangerous activities. The disturbed attachment temperament probably starts with extreme sensitivity to separations or rejections. Another theory has proposed that patients with BPD are born with excessive aggression which is genetically based (as opposed to being environmental in origin). A child born with a placid or passive temperament would be unlikely to ever develop BPD.

The fact that girls are more affiliative, and boys more instrumental, is believed to explain why there is a much higher frequency of females (i.e., approximately 75%) with the BPD diagnosis. This suggests that the disorder may be primarily a disorder of relationships. In contrast, antisocial personality disorder occurs disproportionately in males (about 75% of those diagnosed with antisocial personality disorder are male) and is thought to be primarily a disorder of action.

Normal neurological function is needed for such complex tasks as impulse control, regulation of emotions, and perception of social cues. Studies of BPD patients have identified an increased incidence of neurological dysfunctions, often subtle, that are discernible on close examination. The largest portion of the brain is the cerebrum, the upper section, where information is interpreted coming in from the senses, and from which conscious thoughts and voluntary movements are thought to emanate. Preliminary studies have found that individuals with BPD have a diminished serotonergic response to stimulation in these areas of the cerebrum and that the lower levels of brain activity may promote impulsive behavior. The limbic system, located at the center of the brain, is sometimes thought of as “the emotional brain”, and consists of the amygdala, hippocampus, thalamus, hypothalamus, and parts of the brain stem. There is evidence that the volume of the amygdala and hippocampus portions of the brain, so critical for emotional functioning, are smaller in those with BPD. It is not clear whether such neurological irregularities have either genetic or environmental sources.

In summary, research indicates that individuals who have difficulty with impulse control and aggression have reduced levels of activity in their brains in a number of key locations. It is theorized that in persons with BPD, mild to moderate impairments in several systems result in

“errors” in the gathering, dissemination, and interpretation of data, and they are consequently more likely to respond with acts of impulsivity or aggression.

B Psychological Factors

Like most other mental illnesses, Borderline Personality Disorder does not appear to originate during a specific, discrete phase of development. Recent studies have suggested that pre-borderline children fail to learn accurate ways to identify feelings or to accurately attribute motives in themselves and others (often called failures of “mentalization”). Such children fail to develop basic mental capacities that constitute a stable sense of self and make themselves or others understandable or predictable. One important theory has emphasized the critical role of an invalidating environment. This occurs when a child is led to believe that his or her feelings, thoughts and perceptions are not real or do not matter. About 70% of people with BPD report a history of physical and/or sexual abuse. Childhood traumas may contribute to symptoms such as alienation, the desperate search for protective relationships, and the eruption of intense feeling that characterize BPD. Still, since relatively few people who are physically or sexually abused develop the borderline disorder (or any other psychiatric disorder), it is essential to consider temperamental disposition. Since BPD can develop without such experiences, these traumas are not sufficient or enough by themselves to explain the illness. Still, sexual or other abuse can be the “ultimate” invalidating environment. Indeed, when the abuser is a caretaker, the child may need to engage in splitting (denying feelings of hatred and revulsion in order to preserve the idea of being loved). Approximately 30% of people with BPD have experienced early parental loss or prolonged separation from their parents, experiences believed to contribute to the borderline patient’s fears of abandonment.

People with BPD frequently report feeling neglected during their childhood. Sometimes the sources for this sense of neglect are not obvious and might be due to a sense of not being sufficiently understood. Patients often report feeling alienated or disconnected from their families. Often they attribute the difficulties in communication to their parents. However, the BPD individual’s impaired ability to describe and communicate feelings or needs, or resistance to self-disclosure may be a significant cause of the feelings of neglect and alienation.

Persons who have been adopted are statistically more likely to develop BPD than the general population. Adopted children often fantasize that their “real” biological parents could have and would have protected them from the frustrations and hurts they have experienced. Indeed, the hope and belief that if only such idealized and nurturing caregivers could be found, then life’s problems would be solved, is central to what BPD patients (whether adopted or not) pursue in relationships with others.

C. Social and Cultural Factors

Evidence shows that borderline personality is found in about 1-2% of the population. There may be societal and cultural factors which contribute to variations in its prevalence. A society which is fast-paced, highly mobile, and where family situations may be unstable due to divorce, economic factors, or other pressures on the caregivers, may encourage development of this disorder.

D. Status of Theories Regarding the Origins and Pathology of Borderline Personality Disorder

At this juncture, clinical theorists believe that biogenetic and environmental components are both necessary for the disorder to develop. These factors are varied and complex. Most individuals should be presumed to have a neurobiological propensity for the disorder. Many different environments may further contribute to the development of the disorder. Families providing reasonably nurturing and caring environments may nevertheless see their progeny develop the illness. Many children experience incalculable ravages at the hands of their caregivers, and yet do not display the symptoms of Borderline Personality Disorder. The best explanation appears to be that there is a confluence of environmental factors and a sensitive, emotionally labile child who has difficulty interpreting the world, including the meaning of his or her caregiver’s behaviors.

The Course of Borderline Personality Disorder

Borderline Personality Disorder usually manifests itself in early adulthood, but there is some variability. As individuals with BPD age, their symptoms and/or the severity of the illness usually diminish. Indeed, about 40-50% of borderline patients remit within two years and this rate rises to 75% by six years. Unlike most other major psychiatric disorders, those who do remit from BPD don't usually relapse! These facts make BPD a "good prognosis diagnosis." Studies of the course of BPD have indicated that the first five years of treatment are usually the most crisis-ridden. A series of intense, unstable relationships that end angrily with subsequent self-destructive or suicidal behaviors are characteristic. Although such crises may persist for years, a decrease in the frequency and seriousness of self-destructive behaviors and suicidal ideation are early indications of improvement, and can usually be expected to continue to diminish gradually in frequency and severity over a period of years. A decline in both the number of hospitalizations and days in hospital also occurs over this period. Whereas about 60% of hospitalized BPD patients are readmitted in the first six months, this rate declines to about 35% in the eighteen months to two-year period following an initial hospitalization. In general, psychiatric care utilization gradually diminishes and increasingly involves briefer, less intensive interventions.

Improvements in social functioning proceed more slowly and less completely than do the symptom remissions. About half of the patients diagnosed with BPD eventually achieve relative stability through close relationships, by finding a niche at work, and/or through involvement with social support networks such as AA or a church. While such stabilization does not mean that they are "cured", i.e., that all of the criteria for BPD are in complete remission, the lives of the patients are significantly improved.

Suicidality and Self-Harm Behavior

The most dangerous and fear-inducing features of Borderline Personality Disorder are the self-harm behavior and potential for suicide. An estimated 10% successfully kill themselves. Deliberate self-harm behaviors (sometimes referred to as parasuicidal acts) are a common feature of BPD, occurring in approximately 75% of patients having the diagnosis and in an even higher percentage for those who have been hospitalized. These behaviors result in physical scarring, and even disabling conditions.

Self-harm behavior takes many forms. Patients with BPD often will self-injure without suicidal intent. Most often, the self-injury involves cutting, but can involve burning, hitting, head banging, and hair pulling. Some self-destructive acts are unintentional, or at least are not perceived by the patient as self-destructive, such as promiscuity, bingeing or purging, and blackouts from substance misuse.

BPD individuals may self-medicate, either with alcohol or drugs (both prescribed and street), in an effort to minimize the intensity of their emotions and as a means of regulating their emotions.

The motivations for self-injurious behaviors are complex, may vary from individual to individual, and may serve different purposes at different times. About 40% of self-harming acts done by borderline patients occur during dissociative experiences, times when numbness and emptiness prevail. Patients report that causing themselves physical pain generates a sense of release and relief which temporarily alleviates excruciating emotional feelings. The acts may also be a means of communication to others and/or an attempt to evoke rescuing behaviors. There may even be a neurochemical basis for the self-harming acts – the physical act may result in a release of certain chemicals which inhibit, at least temporarily, the inner turmoil. Specifically, self-injurious acts can bring relief by stimulating production of endorphins, which are naturally occurring opiates produced by the brain in response to pain. For some persons, self-injury may be the only way to experience feelings at all. Self-destructive behaviors can become addictive, and one of the initial and primary components of treatment is to break this cycle.

While 10% of the individuals with Borderline Personality Disorder commit suicide, suicidal ideation (thinking and fantasizing about suicide) is pervasive in the borderline population.

People with BPD sometimes make suicide attempts when they feel alone and unloved, or when life feels so excruciatingly painful as to feel unbearable. Such attempts are sometimes made under the influence of alcohol or drugs, when the individual's inhibitions are compromised. There may be a vaguely conceived plan to be rescued, which represents an attempt to relieve the intolerable feelings of being alone by establishing some connection with others.

In addition to substance abuse, major depression can contribute to the risk of suicide. Approximately 50% of people with BPD are experiencing an episode of major depression when they seek treatment. About 70% have a major depressive episode in their lifetimes. When depression coexists with the inability to tolerate intense emotion, the urge to act impulsively is exacerbated. It is imperative that treaters evaluate the patient's mood carefully, and treat the depression appropriately, which may include the use of medication.

Family members are, understandably, tormented by the threat and/or carrying out of such acts. Reactions, naturally, vary widely, from wanting to protect the patient, to anger at the perceived attention-demanding aspects of the behavior. The risk of suicide incites fear, anger, and helplessness. It is imperative, however, that family members do not assume the primary burden to ensure the patient's safety. Whenever there is a perceived threat of harm, or the patient has already engaged in self-harm, a professional should be contacted.

The borderline individual may plead to keep communications or behaviors secret, but safety must be the priority. The patient, treaters, and family cannot work together effectively without candor, and the threat or occurrence of self-destructive acts cannot be kept secret. This is for the benefit of all concerned. Family members/friends do not have the capacity to live with the specter of these behaviors in their lives, and patients will not progress in their treatment until these behaviors are eliminated.

Once safety concerns have been addressed, through the intervention of professionals, family members/friends can play an important role in diminishing the likelihood of recurring self-destructive threats by simply being present and listening to their loved one, without criticism, rejection, or disapproval.

Current Status of Treatment

In the past few decades, treatment for Borderline Personality Disorder has changed radically, and, in turn, the prognosis for improvement and/or recovery has significantly improved.

One of the preliminary questions confronting families/friends is how and when to place confidence in those responsible for treating the patient. Generally speaking, the more clinical experience the treater(s) have working with borderline patients, the better. In the event that several professionals are involved in the care of a borderline individual, it will be important that they are compatible in their approaches and are communicating with one another. Support by family members of treatment is equally important.

A. Hospitalization

Hospitalization in the care of borderline patients is usually restricted to the management of crises (including, but not limited to, situations where the individual's safety is precarious). Hospitals provide a safe place where the patient has an opportunity to gain distance and perspective on a particular crisis and where professionals can assess the patient's psychological and social problems and resources. It is not uncommon for medication changes to take place in the context of a hospital stay, where professionals can monitor the impact of new medications in a controlled environment. Hospitalizations are usually short in duration.

B. Psychotherapy

Psychotherapy is the cornerstone of most treatments of borderline patients. Although development of a secure attachment to the therapist is generally essential for the psychotherapy to have useful effects, this does not occur easily with the borderline patient, given the intense needs and fears about relationships.

Moreover, therapists are sometimes apprehensive about working with borderline patients. The symptomatology of the borderline patient can be as difficult for professionals as it is for family members. The treater may assume the role of protective caretaker, and then experience feelings of anger and fear when the patient engages in dangerous and maladaptive behaviors. Even very able, motivated therapists are sometimes abruptly terminated by borderline patients. Often, however, while experienced as a failure, these brief therapies turn out to have served a valuable role in helping the patient through an otherwise insurmountable situation.

The standard recommendation for individual psychotherapy involves one to two visits a week with an experienced clinician for a period of one to six years. Good therapists need to be active and maintain consistent expectations of change and patient participation. Essential to successful therapy for a borderline patient is the development of feelings of trust and closeness with the therapist (which may have been missing from the patient's life to that point) with the expectation that this would enhance the ability of the patient to have relationships of this nature with others. Validation is a technique whereby the borderline individual develops recognition and acceptance of the self as unique and worthy.

Two types of psychodynamic (*aka* psychoanalytic) therapies have now been proven effective. Transference-focused psychotherapy (TFP) emphasizes the interpretation of the meaning for the patient's behaviors within relationships, most notably the relationship with the therapist. TFP also emphasizes the importance of experiences of anger. Mentalization-based therapy (MBT) emphasizes the value of recognizing one's own mental states (feelings/attitudes) and those of others as ways of explaining behaviors.

C. Dialectical Behavior Therapy (DBT)

Dialectical Behavior Therapy combines individual and group therapy modalities and is directed at teaching the borderline patient skills to regulate intense emotional states and to diminish self-destructive behaviors. The core of DBT is the concept of mindfulness – which involves awareness and attention to the current situation, and a proper balancing of cognitive and emotional states, resulting in “wise mind”, which is a combination of intuitive knowledge to emotional experience and logical analysis. In addition to the concept of mindfulness, DBT addresses regulating emotions; distress tolerance skills, and effective interpersonal skills. This therapy's proactive, problem-solving approach readily engages borderline patients who are motivated to change.

D. Cognitive Behavioral Therapy (CBT)

Cognitive Behavioral Therapy requires the patient to scrutinize and challenge core beliefs which adversely affect self-perception and ways of interacting with the world. Borderline patients often engage in thinking patterns which are hard to understand and challenge. CBT is more emotionally neutral and structured than psychodynamic therapy, and, especially in the early phases of treatment, may have a significant place within the overall social-rehabilitative strategies needed by many borderline patients.

E. Family Therapy

Parents and spouses often bear a significant burden. They usually feel misjudged and unfairly criticized when the person with BPD blames them for their suffering. Suffice it to say, that for both the borderline patient, and those who love them, living with this disorder is a challenging way to experience life. Often, family members are grateful to be educated about the borderline diagnosis, the likely prognosis, reasonable expectations from treatment, and how they can contribute. Such interventions often improve communication, decrease alienation, and relieve family burdens. Considerable effort is usually required to establish an alliance with family members and the patient before family therapy can be undertaken. Before commencing outpatient family therapy, the borderline patient needs to be motivated to participate and to have established an ability to communicate with words (rather than actions) and to listen. It is equally imperative that the family members' motivation and ability to participate meaningfully be evaluated.

F. Group Therapies

Group therapies include those led by professionals, with selected membership, and self-help groups, comprised of people who gather together to discuss common problems. Both are effective treatments.

DBT and CBT interventions are often like classrooms with much focus and direction offered by the group leader and with homework between sessions. Borderline patients may be resistant to interpersonal or psychodynamic groups which require the expression of strong feelings or the need for personal disclosures. However, such forums may be useful for these very reasons. Moreover, such groups offer an opportunity for borderline patients to learn from persons with similar life experiences, which, in conjunction with the other modalities discussed here, can significantly enhance the treatment course.

Many borderline patients will find it more acceptable to join self-help groups, such as AA, and other groups that are directed to problems such as eating disorders or that have purely supportive functions, such as Survivors of Incest. Such self-help groups that provide a network of supportive peers can be useful as an adjunct to treatment, but should not be relied on as the sole source of support.

Conclusion

Borderline Personality Disorder is a relative newcomer to psychiatry's diagnostic system. Despite its prevalence in clinical settings and its enormous public health costs, the disorder has only recently begun to command the attention it requires. This is evident in the emergence of parental advocacy/education/support groups, in the identification of BPD as a priority by the National Institute of Mental Health (NIMH) and by the National Alliance on Mental Illness (NAMI) in 2006.

Our understanding of the disorder itself is in the process of dramatic change. Where its etiology was once thought to be exclusively environmental, we now know it is heavily genetic. Where it was thought to be a highly chronic, resistant-to-change disorder, we now know it has a remarkably good prognosis. Finally, where once it was thought to require heroic commitments to undertake BPD treatment, we now have a variety of interventions specifically designed for BPD which can have significant benefits.

RESOURCES

Behavioral Tech

DBT referral, training, and resources

4556 University Way NE, Suite 200, Seattle, WA 98105

(206) 675-8588

www.behavioraltech.com

information@behavioraltech.org

Borderline Personality Disorder Resource Center

BPD referral to resources and treatment

New York-Presbyterian Hospital-Westchester Division

Macy Villa, 21 Bloomingdale Road,

White Plains, New York, 10605

(888) 694-2273

www.bpdresourcecenter.org

info@bpdresourcecenter.org

Middle Path

DBT and BPD peer resources, advocacy and education

PO Box 541 481

Waltham, MA 02454

www.middle-path.org

interest@middle-path.org

National Education Alliance for Borderline Personality Disorder (NEA-BPD)

BPD conferences, publications, videos, and education

PO Box 974, Rye, NY 10580

(914) 835-9011

www.borderlinepersonalitydisorder.com

neabpd@aol.com

NEA-BPD ©Family Connections

12-week course for relatives that provides education, coping skill strategies, and support

(914) 835-9011

www.borderlinepersonalitydisorder.com

info@neabpd.org

New England Personality Disorder Association (NEPDA)

BPD family workshops, regional conferences, education, advocacy, and support

115 Mill St. Belmont MA 02478

(617) 855-2680

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The Borderline Personality Disorder Resource Center

FAMILY GUIDELINES

*Multiple Family Group Program
at
McLean Hospital*

by

*John G. Gunderson, M.D.
and
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GOALS: GO SLOWLY _____

- 1. Remember that change is difficult to achieve and fraught with fears. Be cautious about suggesting that “great” progress has been made or giving “You can do it” reassurances. Progress evokes fears of abandonment.**

The families of people with Borderline Personality Disorder can tell countless stories of instances in which their son or daughter went into crisis just as that person was beginning to function better or to take on more responsibility. The coupling of improvement with a relapse is confusing and frustrating but has a logic to it. When people make progress - by working, leaving day treatment, helping in the home, diminishing self-destructive behaviors, or living alone- they are becoming more independent. They run the risk that those around them who have been supportive, concerned, and protective will pull away, concluding that their work is done. The supplies of emotional and financial assistance may soon dry up, leaving the person to fend for herself in the world. Thus, they fear abandonment. Their response to the fear is a relapse. They may not make a conscious decision to relapse, but fear and anxiety can drive them to use old coping methods. Missed days at work, self-mutilation, a suicide attempt, or a bout of overeating, purging or drinking may be a sign that lets everyone around know that the individual remains in distress and needs their help. Such relapses may compel those around her to take responsibility for her through protective measures such as hospitalization. Once hospitalized, she has returned to her most regressed state in which she has no responsibilities while others take care of her.

When signs of progress appear, family members can reduce the risk of relapse by not showing too much excitement about the progress and by cautioning the individual to move slowly. This is why experienced members of a hospital staff tell borderline patients during discharge *not* that they feel confident about their prospects, but that they know the patient will confront many hard problems ahead. While it is important to acknowledge progress with a pat on the back, it is meanwhile necessary to convey understanding that progress is very difficult to achieve. It does not mean that the person has overcome her emotional struggles. You can do this by avoiding statements such as, “You’ve made great progress,” or, “I’m so impressed with the change in you.” Such messages imply that you think they are well or over their prior problems. Even statements of reassurance such as, “That wasn’t so hard,” or, “I knew you could do it,” suggest that you minimize their struggle. A message such as, “Your progress shows real effort. You’ve worked hard. I’m pleased that you were able to do it, but I’m worried that this is all too stressful for you,” can be more empathic and less risky.

- 2. Lower your expectations. Set realistic goals that are attainable. Solve big problems in small steps. Work on one thing at a time. “Big”, long-term goals lead to discouragement and failure.**

Although the person with BPD may have many obvious strengths such as intelligence, ambition, good looks, and artistic talent, she nonetheless is handicapped by severe emotional vulnerabilities as she sets about making use of those talents. Usually the person with BPD and her family members have aspirations based upon these strengths. The patient or her family may push for return to college, graduate school, or a training program that will prepare her for financial independence. Family members may wish to have the patient move into her own apartment and care for herself more independently. Fueled by such high ambitions, a person with BPD will take a large step forward at a time. She may insist upon returning to college full time despite undergoing recent hospitalizations, for example. Of course, such grand plans do not consider the individual’s handicaps of affect dyscontrol, black and white thinking, and intolerance of aloneness. The first handicap may mean that, in the example given, the B received on the first exam could lead to an inappropriate display of anger if it was thought to be unfair, to a self-destructive act if it was felt to be a total failure, or severe anxiety if it was believed that success in school would lead to decreased parental concern. The overriding issue about success in the vocational arena is the threat of independence —much desired but fraught with fear of abandonment. The result of too large a step forward all at once is often a crashing swing in the opposite direction, like the swing of a pendulum. The person often relapses to a regressed state and may even require hospitalization.

A major task for families is to slow down the pace at which they or the patient seeks to achieve goals. By slowing down, they prevent the sharp swings of the pendulum as described and prevent experiences of failure that are blows to the individual's self-confidence. By lowering expectations and setting small goals to be achieved step by step, patients and families have greater chances of success without relapse. Goals must be realistic. For example, the person who left college mid-semester after becoming depressed and suicidal under the pressure most likely could not return to college full time a few months later and expect success. A more realistic goal is for that person to try one course at a time while she is stabilizing. Goals must be achieved in small steps. The person with BPD who has always lived with her parents might not be able to move straight from her parents' home. The plan can be broken down into smaller steps in which she first moves to a halfway house, and then into a supervised apartment. Only after she has achieved some stability in those settings should she take the major step of living alone.

Goals should not only be broken down into steps but they should be taken on one step at a time. For example, if the patient and the family have goals for both the completion of school and independent living, it may be wisest to work on only one of the two goals at a time.

FAMILY ENVIRONMENT

3. Keep things cool and calm. Appreciation is normal. Tone it down. Disagreement is normal. Tone it down, too.

This guideline is a reminder of the central message of our educational program: The person with BPD is handicapped in his ability to tolerate stress in relationships (i.e., rejection, criticism, disagreements) and can, therefore, benefit from a cool, calm home environment. It is vital to keep in mind the extent to which people with BPD struggle emotionally each day. While their internal experience can be difficult to convey, we explain it by summarizing into three handicaps: affect dyscontrol, intolerance of aloneness, and black and white thinking. To review:

Affect Dyscontrol:

A person with BPD has feelings that dramatically fluctuate in the course of each day and that are particularly intense. These emotions, or affects, often hit hard. We have all experienced such intense feelings at times. Take for example the sensation of pounding heart and dread that you may feel when you suddenly realize that you have made a mistake at work that might be very costly or embarrassing to your business. The person with BPD feels such intense emotion on a regular basis. Most people can soothe themselves through such emotional experiences by telling themselves that they will find a way to compensate for the mistake or reminding themselves that it is only human to make mistakes. The person with BPD lacks that ability to soothe herself. An example can also be drawn from family conflict. We have all had moments in which we feel rage towards the people we love. We typically calm ourselves in such situations by devising a plan for having a heart-to-heart talk with the family member or by deciding to let things blow over. The person with BPD again feels such rage in its full intensity and without being able to soothe himself through the use of coping strategies. It results in an inappropriate expression of hostility or by acting out of feelings (drinking or cutting).

Intolerance of Aloneness:

A person with BPD typically feels desperate at the prospect of any separation - a family member's or therapist's vacation, break up of a romance, or departure of a friend. While most of us would probably miss the absent family member, therapist or friend, the person with BPD typically feels intense panic. She is unable to conjure up images of the absent person to soothe herself. She cannot tell herself, "That person really cares about me and will be back again to help me." Her memory fails her. She only feels soothed and cared for by the other person when that person is present. Thus, the other person's absence is experienced as abandonment. She may even keep these painful thoughts and feelings out of mind by using a defense

mechanism called *dissociation*. This consists of a bizarre and disturbing feeling of being unreal or separate from one's body.

Black & White Thinking (Dichotomous Thinking):

Along with extremes of emotion come extremes in thinking. The person with BPD tends to have extreme opinions. Others are often experienced as being either all good or all bad. When the other person is caring and supportive, the person with BPD views him or her as a savior, someone endowed with special qualities. When the other person fails, disagrees, or disapproves in some way, the person with BPD views him or her as being evil and uncaring. The handicap is in the inability to view other people more realistically, as mixtures of good and bad qualities.

This review of the handicaps of people with BPD is a reminder that they have a significantly impaired ability to tolerate stress. Therefore, the family members can help them achieve stability by creating a cool, calm home environment. This means slowing down and taking a deep breath when crises arise rather than reacting with great emotion. It means setting smaller goals for the person with BPD so as to diminish the pressure she is experiencing. It means communicating when you are calm and in a manner that is calm. It does not mean sweeping disappointments and disagreements under the rug by avoiding discussion of them. It does mean that conflict needs to be addressed in a cool but direct manner without use of put-downs. Subsequent guidelines will provide methods for communicating in this fashion.

4. Maintain family routines as much as possible. Stay in touch with family and friends. There's more to life than problems, so don't give up the good times.

Often, when a member of the family has a severe mental illness, everyone in the family can become isolated as a result. The handling of the problems can absorb much time and energy. People often stay away from friends to hide a problem they feel as stigmatizing and shameful. The result of this isolation can be only anger and tension. Everyone needs friends, parties, and vacations to relax and unwind. By making a point of having good times, everyone can cool down and approach life's problems with improved perspective. The home environment will naturally be cooler. So you should have good times not only for your own sake, but for the sake of the whole family.

5. Find time to talk. Chats about light or neutral matters are helpful. Schedule times for this if you need to.

Too often, when family members are in conflict with one another or are burdened by the management of severe emotional problems, they forget to take time out to talk about matters other than illness. Such discussions are valuable for many reasons. The person with BPD often devotes all her time and energy to her illness by going to multiple therapies each week, by attending day treatment, etc. The result is that she misses opportunities to explore and utilize the variety of talents and interests she has. Her sense of self is typically weak and may be weakened further by this total focus on problems and the attention devoted to her being ill. When the family members take time to talk about matters unrelated to illness, they encourage and acknowledge the healthier aspects of her identity and the development of new interests. Such discussions also lighten the tension between family members by introducing some humor and distraction. Thus, they help you to follow guideline #3.

Some families never talk in this way, and to do so may seem unnatural and uncomfortable at first. There may be a hundred reasons why there is no opportunity for such communication. Families need to make the time. The time can be scheduled in advance and posted on the refrigerator door. For example, everyone may agree to eat dinner together a few times a week with an agreement that there will be no discussions of problems and conflict at these times. Eventually, the discussions can become habit and scheduling will no longer be necessary.

MANAGING CRISES

PAY ATTENTION BUT STAY CALM

6. Don't get defensive in the face of accusations and criticisms. However unfair, say little and don't fight. Allow yourself to be hurt. Admit to whatever is true in the criticisms.

When people who love each other get angry at each other, they may hurl heavy insults in a fit of rage. This is especially true for people with BPD because they tend to feel a great deal of anger. The natural response to criticism that feels unfair is to defend oneself. But, as anyone who has ever tried to defend oneself in such a situation knows, defending yourself doesn't work. A person who is enraged is not able to think through an alternative perspective in a cool, rational fashion. Attempts to defend oneself only fuel the fire. Essentially, defensiveness suggests that you believe the other person's anger is unwarranted, a message that leads to greater rage. Given that a person who is expressing rage with words is not posing threat of physical danger to herself or others, it is wisest to simply listen without arguing.

What that individual wants most is to be heard. Of course, listening without arguing means getting hurt because it is very painful to recognize that someone you love could feel so wronged by you. Sometimes the accusations hurt because they seem to be so frankly false and unfair. Other times, they may hurt because they contain some kernel of truth. If you feel that there is some truth in what you're hearing, admit it with a statement such as, "I think you're on to something. I can see that I've hurt you and I'm sorry."

Remember that such anger is part of the problem for people with BPD. It may be that she was born with a very aggressive nature. The anger may represent one side of her feelings which can rapidly reverse. (See discussion of black and white thinking.) Keeping these points in mind can help you to avoid taking the anger personally.

7. Self-destructive acts or threats require attention. Don't ignore. Don't panic. It's good to know. Do not keep secrets about this. Talk about it openly with your family member and make sure professionals know.

There are many ways in which the person with BPD and her family members may see trouble approaching. Threats and hints of self-destructiveness may include a variety of provocative behaviors. The person may speak of wanting to kill herself. She may become isolative. She may superficially scratch herself. Some parents have noticed that their daughters shave their head and color their hair neon at times when they are in distress. More commonly, what will be evident is not eating or reckless behavior. Sometimes the evidence is blunt - a suicide gesture made in the parent's presence. Trouble may be anticipated when separations or vacations occur.

When families see the signs of trouble they may be reluctant to address them. Sometimes the person with BPD will insist that her family "butt out." She may appeal to her right to privacy. Other times, family members dread speaking directly about a problem because the discussion may be difficult. They may fear that they would cause a problem where there might not be one by "putting ideas into someone's head". In fact, families fear for their daughter's safety in these situations because they know their daughters well and know the warning signs of trouble from experience. Problems are not created by asking questions. By addressing provocative behaviors and triggers in advance, family members can help to avert further trouble. People with BPD often have difficulty talking about their feelings and instead tend to act on them in destructive ways. Therefore, addressing a problem openly by inquiring with one's daughter or speaking to her therapist helps her to deal with her feelings using words rather than actions.

Privacy is, of course, a great concern when one is dealing with an adult. However, the competing value in these situations of impending danger is safety. When making difficult decisions about whether to call your loved one's therapist about a concern or call an ambulance, one must weight concern for safety against concern for privacy. Most people would agree that safety comes first. There may be a temptation to under-

react in order to protect the individual's privacy. At the same time, there may be a temptation to overreact in ways that give the person reinforcement for her behavior. One young woman with BPD told her mother excitedly during an ambulance ride to a psychiatric hospital, "I've never been in an ambulance before!" Families must apply judgment to their individual situation. Therapists can be helpful in anticipating crises and establishing plans that fit the individual family's needs.

8. Listen. People need to have their negative feelings heard. Don't say, "It isn't so." Don't try to make the feelings go away. Using words to express fear, loneliness, inadequacy, anger, or needs is good. It's better to use words than to act out on feelings.

When feelings are expressed openly, they can be painful to hear. A daughter may tell her parents that she feels abandoned or unloved by them. A parent may tell his child that he's at the end of his rope with frustration. Listening is the best way to help an emotional person to cool off. People appreciate being heard and having their feelings acknowledged. This does not mean that you have to agree. Let's look at the methods for listening. One method is to remain silent while looking interested and concerned. You may ask some questions to convey your interest. For example, one may ask, "How long have you felt this way?" or "What happened that triggered your feelings?" Notice that these gestures and questions imply interest but not agreement. Another method of listening is to make statements expressing what you believe you've heard. With these statements, you prove that you are actually hearing what the other person is saying. For example, if your daughter tells you she feels like you don't love her, you can say, even as you are contemplating how ridiculous that belief is, "You feel like I don't love you!?" When a child is telling her parents that she feels as if she has been treated unfairly by them, parents may respond, "You feel cheated, huh?" Notice once again, these empathic statements do not imply agreement.

Do not rush to argue with your family member about her feelings or talk her out of her feelings. As we said above, such arguing can be fruitless and frustrating to the person who wants to be heard. Remember, even when it may feel difficult to acknowledge feelings that you believe have no basis in reality, it pays to reward such expression. It is good for people, especially individuals with BPD, to put their feelings into words, no matter how much those feelings are based on distortions. If people find the verbal expression of their feelings to be rewarding, they are less likely to act out on feelings in destructive ways.

Feelings of being lonely, different, and inadequate need to be heard. By hearing them and demonstrating that you have heard them using the methods described above, you help the individual to feel a little less lonely and isolated. Such feelings are a common, everyday experience for people with BPD. Parents usually do not know and often do not want to believe that their daughter feels these ways. The feelings become a bit less painful once they are shared.

Family members may be quick to try to talk someone out of such feelings by arguing and denying the feelings. Such arguments are quite frustrating and disappointing to the person expressing the feelings. If the feelings are denied when they are expressed verbally, the individual may need to act on them in order to get her message across.

ADDRESSING PROBLEMS COLLABORATE AND BE CONSISTENT

- 9. When solving a family member's problems, ALWAYS:**
- a) involve the family member in identifying what needs to be done
 - b) ask whether the person can "do" what's needed in the solution
 - c) ask whether they want you to help them "do" what's needed

Problems are best tackled through open discussion in the family. Everyone needs to be part of the discussion. People are most likely to do their part when they are asked for their participation and their views about the solution are respected.

It is important to ask each family member whether he or she feels able to do the steps called for in the planned solution. By asking, you show recognition of how difficult the task may be for the other person. This goes hand in hand with acknowledging the difficulty of changing.

You may feel a powerful urge to step in and help another family member. Your help may be appreciated or may be an unwanted intrusion. By asking if your help is wanted before you step in, your assistance is much less likely to be resented.

10. Family members need to act in concert with one another. Parental inconsistencies fuel severe family conflicts. Develop strategies that everyone can stick to.

Family members may have sharply contrasting views about how to handle any given problem behavior in their relative with BPD. When they each act on their different views, they undo the effect of each other's efforts. The typical result is increasing tension and resentment between family members as well as lack of progress in overcoming the problem.

An example will illustrate the point. A daughter frequently calls home asking for financial bail outs. She has developed a large credit card debt. She wants new clothing. She has been unable to save enough money to pay her rent. Despite her constant desire for funds, she is unable to take financial responsibility by holding down a job or living by a budget. Her father expresses a stern attitude, refusing to provide the funds, and with each request and insisting that she take responsibility for working out the problem herself. The mother meanwhile softens easily with each request and gives her the funds she wants. She feels that providing the extra financial help is a way of easing the daughter's emotional stress. The father then resents the mother's undoing of his efforts at limit setting while the mother finds the father to be excessively harsh and blames him for the daughter's worsening course. The daughter's behavior persists, of course, because there is no cohesive plan for dealing with the financial issue that both parents can stick to. With some communication, they can develop a plan that provides an appropriate amount of financial support, one that would not be viewed as too harsh by the mother, but would not be considered excessively generous in the father's eyes. The daughter will adhere to the plan only after both parents adhere to it.

Brothers and sisters can also become involved in these family conflicts and interfere with each other's efforts in handling problems. In these situations, family members need to communicate more openly about their contrasting views on a problem, hear each other's perspectives, and then develop a plan that everyone can stick to.

11. If you have concerns about medications or therapist interventions, make sure that both your family member and his or her therapist/doctor/treatment team know. If you have financial responsibility, you have the right to address your concerns to the therapist or doctor.

Families may have a variety of concerns about their loved one's medication usage. They may wonder whether the psychiatrist is aware of the side effects the patient is experiencing. Can the psychiatrist see how sedated or obese the individual has become? Is he or she subjecting the patient to danger by prescribing too many medications? Families and friends may wonder if the doctor or therapist knows the extent of the patient's non-compliance or history of substance abuse.

When family members have such concerns, they often feel that they should not interfere, or are told by the patient not to interfere. We feel that if family members play a major supportive role in the patient's life, such as providing financial support,

emotional support, or by sharing their home, they should make efforts to participate in treatment planning for that individual. They can play that role by contacting the doctor or therapist directly themselves to express their concerns. Therapists cannot release information about patients who are over the age of 18 without consent, but they can hear and learn from the reports of the patient's close family and friends. Sometimes they will work with family members or friends but obviously with their patient's consent.

LIMIT SETTING _____ ***BE DIRECT BUT CAREFUL***

12. Set limits by stating the limits of your tolerance. Let your expectations be known in clear, simple language. Everyone needs to know what is expected of them.

Expectations need to be set forth in a clear manner. Too often, people assume that the members of their family should know their expectations automatically. It is often useful to give up such assumptions.

The best way to express an expectation is to avoid attaching any threats. For example, one might say, "I want you to take a shower at least every other day." When expressed in that fashion, the statement puts responsibility on the other person to fulfill the expectation. Often, in these situations, family members are tempted to enforce an expectation by attaching threats. When feeling so tempted, one might say, "If you don't take a shower at least every other day, I will ask you to move out." The first problem with that statement is that the person making the statement is taking on the responsibility. He is saying "I" will take action if "you" do not fulfill your responsibility as opposed to giving the message, "*You need to take responsibility!*" The second problem with that statement is that the person making it may not really intend to carry out the threat if pushed. The threat becomes an empty expression of hostility. Of course, there may come a point at which family members feel compelled to give an ultimatum with the true intention to act on it. We will discuss this situation later.

13. Do not protect family members from the natural consequences of their actions. Allow them to learn about reality. Bumping into a few walls is usually necessary.

People with BPD can engage in dangerous, harmful, and costly behaviors. The emotional and financial toll to the individual and the family can be tremendous. Nonetheless, family members may sometimes go to great lengths to give in to the individual's wishes, undo the damage, or protect everyone from embarrassment. The results of these protective ways are complex. First and foremost, the troublesome behavior is likely to persist because it has cost no price or has brought the individual some kind of reward. Second, the family members are likely to become enraged because they resent having sacrificed integrity, money, and good will in their efforts to be protective. In this case, tensions in the home mount even though the hope of the protective measures was to prevent tension. Meanwhile, the anger may be rewarding on some level to the individual because it makes her the focus of attention, even if that attention is negative. Third, the individual may begin to show these behaviors outside of the family and face greater harm and loss in the real world than she would have faced in the family setting. Thus, the attempt to protect leaves the individual unprepared for the real world. Some examples will illustrate the point.

A daughter stuffs a handful of pills in her mouth in her mother's presence. The mother puts her hand into the daughter's mouth to sweep out the pills. It is reasonable to prevent medical harm in this way. The mother then considers calling an ambulance because she can see that the daughter is suicidal and at risk of harming herself. However, this option would have some very negative consequences. The daughter and the family would face the embarrassment of having an ambulance in front of the house. The daughter does not wish to go to the hospital and would become enraged and out of control if the mother called the ambulance. A mother in this situation would be strongly tempted not to call the ambulance in order to avoid the daughter's wrath and to preserve the family's image in the neighborhood. She might rationalize the decision by convincing herself that

the daughter is not in fact in immediate danger. The primary problem with that choice is that it keeps the daughter from attaining much needed help at a point when she has been and could still be suicidal. The mother would be aiding the daughter in denial of the problem. Medical expertise is needed to determine whether the daughter is at risk of harming herself. If the daughter's dramatic gesture has not been given sufficient attention, she would be likely to escalate. As she escalates, she may make an even more dramatic gesture and face greater physical harm. Furthermore, if an ambulance were not called for fear of incurring her wrath, she would receive the message that she can control others by threatening to become enraged

A 25-year old woman steals money from her family members while she is living with them. The family members express great anger at her and sometimes threaten to ask her to move out, but they never take any real action. When she asks to borrow money, they give the loan despite the fact that she never pays back such loans. They fear that if they do not lend the money, she may steal it from someone outside the family, thus leading to legal trouble for her and humiliation for everyone else involved. In this case, the family has taught the daughter that she can get away with stealing. She has essentially blackmailed them. They give her what she wants because they are living with fear. The daughter's behavior is very likely to persist as long as no limits are set on it. The family could cease to protect her by insisting that she move out or by stopping the loans. If she does steal from someone outside the family and faces legal consequences, this may prove to be a valuable lesson about reality. Legal consequences may influence her to change and subsequently function better outside the family.

A 20-year old woman who has had multiple psychiatric hospitalizations recently and has been unable to hold down any employment decides that she wants to return to college full time. She asks her parents to help pay tuition. The parents who watch their daughter spend most of her day in bed are skeptical that she will be able to remain in school for an entire semester and pass her courses. The tuition payments represent great financial hardship for them. Nonetheless, they agree to support the plan because they do not want to believe she is as dysfunctional as she behaves and they know their daughter will become enraged if they do not. They have given a dangerous "You can do it" message. Furthermore, they have demonstrated to her that displays of anger can control her parents' choices. A more realistic plan would be for the daughter to take one course at a time to prove that she can do it, and then return to school full time only after she has demonstrated the ability to maintain such a commitment despite her emotional troubles. In this plan, she faces a natural consequence for her recent low functioning. The plan calls upon her to take responsibility in order to obtain a privilege she desires.

Each of the cases illustrates the hazards of being protective when a loved one is making unwise choices or engaging in frankly dangerous behavior. By setting limits on these choices and behaviors, family members can motivate individuals to take on greater responsibility and have appropriate limits within themselves. The decision to set limits is often the hardest decision for family members to make. It involves watching a loved one struggle with frustration and anger. It is important for parents to remember that their job is not to spare their children these feelings but to teach them to live with those feelings as all people need to do.

**14. Do not tolerate abusive treatment such as tantrums, threats, hitting and spitting.
Walk away and return to discuss the issue later.**

Frank tantrums are not tolerable. There is a range of ways to set limits on them. A mild gesture would be to walk out of the room to avoid rewarding the tantrum with attention. A more aggressive gesture would be to call an ambulance. Many families fear taking the latter step because they do not want an ambulance in front of their home, or they do not want to incur the wrath of the person having the tantrum. When torn by such feelings, one must consider the opposing issues. Safety may be a concern when someone is violent and out of control. Most people would agree that safety takes priority over privacy. Furthermore, by neglecting to get proper medical attention for out-of-control behavior, one may turn a silent ear to it. This only leads to further escalation. The acting out is a cry for help. If a cry for help is not heard, it only becomes louder.

15. Be cautious about using threats and ultimatums. They are a last resort. Do not use threats and ultimatums as a means of convincing others to change. Give them only

when you can and will carry through. Let others - including professionals - help you decide when to give them.

When one family member can no longer tolerate another member's behavior, he or she may reach the point of giving an ultimatum. This means threatening to take action if the other person does not cooperate. For example, when a daughter will not take a shower or get out of bed much of the day, an exasperated parent may want to tell her that she will have to move out if she does not change her ways. The parent may hope that fear will push her to change. At the same time, the parent may not be serious about the threat. When the daughter continues to refuse to cooperate, the parent may back down, proving that the threat was an empty one. When ultimatums are used in this way, they become useless, except to produce some hostility. Thus, people should only give ultimatums when they seriously intend to act on them. In order to be serious about the ultimatum, the person giving it probably has to be at the point where he feels unable to live with the other person's behavior.

RESOURCES FOR BORDERLINE PERSONALITY DISORDER

American Psychiatric Association
1000 Wilson Boulevard, Suite 1825
Arlington, VA 22209-2901
888 357-7924 or 703 907-7300 Apa@psych.org www.psych.org

American Academy of Child and Adolescent Psychiatry, AACAP
3615 Wisconsin Avenue N.W., Washington, DC 20016-3007
Office: 202 966-7300 Fax: 202 966-2891 www.aacap.org

Behavioral Tech - DBT referral, training, and resources
4556 University Way NE, Suite 200, Seattle, WA 98105
206 675-8588 www.behavioraltech.com information@behavioraltech.org

Borderline Personality Disorder Resource Center
BPD referral to resources and treatment
21 Bloomingdale Road
White Plains, NY 10605
888 694-2273 www.bpdresourcecenter.org info@bpdresourcecenter.org

www.BPDdemystified.com A comprehensive website created in November of 2006 and updated periodically by Robert O. Friedel, M.D., Clinical Professor of Psychiatry at Virginia Commonwealth University/Medical College of Virginia. He has established and directed Borderline Personality Disorder Clinics at the University of Alabama, Birmingham, and currently at Virginia Commonwealth University. He serves on the Scientific Advisory Board of the National Education Alliance for Borderline Personality and the educational board of the Journal of Clinical Psychopharmacology. He has authored a book, published in 2004, titled Borderline Personality Disorder Demystified - An Essential Guide for Understanding and Living with BPD.

BPD Central
P.O. Box 070106, Milwaukee, WI, 53207-0106 888 357-4355 and 800 431-1579
BPDcentral@aol.com www.bpdcentral.com

The Carter Center Mental Health Program
One Copenhill
453 Freedom Parkway, Atlanta, GA 30307
carter web@emory.edu www.cartercenter.org

Florida Borderline Personality Disorder Association www.fbpda.org
233 #rd St. North, Suite 103
St. Petersburg, FL 33701 941 704-4328 Amanda L. Smith, Executive Director

Middle Path
DBT and BPD peer resources, advocacy and education
Po Box 541 481
Waltham, MA 02454 www.middle-path.org interest@middle-path.org

National Alliance on Mental Illness (NAMI) www.nami.org

Colonial Place Three 2107 Wilson Blvd., Suite 300, Arlington, VA 22201-304
6264 703 524-7600 Fax: 703 524-9094

1-800 950-

NATIONAL EDUCATION ALLIANCE FOR BORDERLINE PERSONALITY DISORDER (NEA-BPD)
BPD conferences, publications, videos, and education course - Family Connections - Tele-Connections
PO Box 974
Rye, NY 10580
914 835-9011

www.borderlinepersonalitydisorder.com

neabpd@aol.com

National Institute for Mental Health (NIMH)

Public Inquiries:

6001 Executive Blvd., Rm. 8184, MSC 9663

Bethesda, MD., 20892-9663

301 443-4513 1 866 615-6464 Fax: 301 443-4279

www.nimh.nih.gov

nimhinfo@nih.gov

NEA-BPD FAMILY CONNECTIONS AND TELE-CONNECTIONS

12-week course for relatives that provides education, coping skill strategies, and support

914 835-9011

www.borderlinepersonalitydisorder.com

info@neabpd.org

National Mental Health America (NMHA)

2001 N. Beauregard St, 12th Floor, Alexandria, VA 22311

800 969-6642 703 684-7722 Fax: 703 684-5968

Infoctr@nmha.org

www.nmha.org

New England Personality Disorder Association (NEPDA)

BPD family workshops, regional conferences, education, advocacy, and support

115 Mill St. Belmont, MA 02478

617 855-2680

www.nepda.org

info@nepda.org

Treatment and Research Advancements

National Association for Personality Disorder (TARA NAPD)

23 Greene Street, New York, NY 10013

212 966-6514

www.TARA4BPD.org

BOOKS AND REFERENCES:

A BPD Brief - Revised 2006 by John G. Gunderson, M.D., Director, Center for Treatment and Research on Borderline Personality Disorder, McLean Hospital, Belmont, MA; Professor in Psychiatry, Harvard Medical School, Boston, MA.

Copies may be ordered from: The BPD Resource Center, (888) 694-2273 or email:

info@bpdresourcecenter.org

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edited by John G. Gunderson, M.D., and Perry D. Hoffman, Ph.D., American Psychiatric Publishing, 2005.
Dr. Gunderson is Director, Center for Treatment and Research on Borderline Personality Disorder, McLean Hospital, Belmont, Massachusetts and Professor in Psychiatry, Harvard. Dr. Hoffman is President of the National Education Alliance for Borderline Personality Disorder and co-creator of Family Connections, the 12 week psycho education course for families and friends of those with the symptoms of BPD