WHAT IS PERSONALITY DISORDER?

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

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

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

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

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

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

**How TARA4BPD Helps**

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

**HELPLINE & REFERRALS**

1-888-4-TARABPD
212-966-6514

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

**JOIN TARA NOW and DONATE**

Name ____________________________
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EXP ____________ Join/Donate ______ Amount ______
Individual $75, Family/Prof $100. Make checks payable to TARA4BPD. 501(C)3 nonprofit org. All Contributions are lawfully tax deductible.
BP CD-OCCURRING DISORDERS
- 85% lifetime prevalence for comorbidities
- 49% have an impulse-control disorder, most intermit- tently explosive disorder
- 61% have an anxiety disorder (specific phobia, social phobia)
- 20% have bipolar disorder
- 23%-40% of people with eating disorders also have BPD
- 30% of chronic pain patients have BPD
- Immune Disorders: 26% have fibromyalgia
- Chronic Fatigue 11%, IBS 6%
- 22% afflicted with HIV

BP DAND THE LAW
- 45% of prison inmates (42% male, 52% female)
- 1/3 of male batters
- 1/3 of stalkers
- 25% of self-reported road rage perpetrators
- Male BPD incarcerated for violence

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

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BPD TREATMENT

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

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

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

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

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

SHAME: THE COMMON DENOMINATOR OF BPD REACTIONS

According to Dr. Dvoskin, in Comm. of the NYS Office of MH, “why would psychiatry and psy- chology turn so viciously against people they call mentally disordered? Apparently the great- est sin a client can commit is poor response, they have yet to demonstrate the ability to get better in response to our treatment. Thus, they don’t make us feel very good. With a few notable exceptions, we have simply given up on helping people who desperately need us to do a better job of helping them.”

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

COMPASSION FOCUSED THERAPY
Developed by Paul Gilbert, it integrates cognitive behavioral therapy, evolutionary psychology, social and developmental psychology, Buddhist principles, & neuroscience. It uses compassionate mind train- ing to help develop experiences of inner warmth, semblence and soothing, via compassion & self- compassion. CFT is especially helpful for those with high levels of shame and self-criticism and have diffi- culty feeling warm toward, being kind to them- selves or others.

SCHEMA THERAPY
Developed by J. Young, it integrates elements of cognitive therapy, behavior therapy, object rela- tions and gestalt therapy. It helps change disorga- nized distress negative (“maladaptive”) & self-defeating patterns or schema a person has lived with for a long time. The targeted schemas typically begin early in life.

WHY DON'T WE DEVELOP BPD?
Latest research indicates BPD is a biologically based disorder with a major genetic component (Heritability 74% Torgerson). Biological “vulner- abilities” place a person at risk. They are generally hypersensitive to sensory stimuli (noise, odors & textures), are either hyper/hypersensitive to pain, have difficulty sleeping, often beginning in child- hood. They have memory deficits, often exagger- ating negative events. Difficulty labeling what they feel leads to frequent misdiagnosis. They also suffer from autoimmune disorders.

HOW FAMILIES CAN HELP
With understanding and training, family members can be- come part of the solution, rather than part of the problem. As they play an integral part in helping, they must learn all about BPD. The National Alliance in Overcoming Doubleily Personality Disorder: A Family Guide for Healing and Change by Valerie Por, offers evidence-based methods to improve and repair relationships, decrease frequency and intensity of escalations while reinforcing adaptive coping. With compas- sion, educated family members can avoid suicide threats and attempts. Families can advocate for appropriate BPD treat- ment and increased research funding.

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