A BPD BRIEF

An Introduction to Borderline Personality Disorder

Diagnosis, Origins, Course, and Treatment

by

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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 amgydala 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, binging 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
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