BPD At a Glance

A Challenging but Treatable Disorder
BPD is a serious mental illness that centers on the inability to manage emotions effectively.

The symptoms include: fear of abandonment, impulsivity, anger, bodily self-harm, suicide, and chaotic relationships. 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.

Officially recognized in 1980 by the psychiatric community, BPD is more than two decades behind in research, treatment options, and family psycho-education compared to other major psychiatric disorders. BPD has historically met with widespread misunderstanding and blatant stigma. However, evidenced-based treatments have emerged over the past two decades bringing hope to those diagnosed with the disorder and their loved ones.

Prevalence
- afflicts up to 5.9% of adults (approx. 14 million Americans)
- is more common than schizophrenia and bipolar disorder
- 20% of inpatients admitted to psychiatric hospitals, 10% of outpatients have BPD

Suicide and Self-Injury
- 10% of adults with BPD commit suicide
- 55-85% of adults with BPD self-injure their bodies
- 33% of youth who commit suicide have features of BPD

Treatment Challenges
- evidence-based therapies exist but need wider dissemination
- about 85% of people with BPD also meet the diagnostic criteria of another mental disorder
- a 30-year woman with BPD typically has the medical profile of a woman in her 60s
- 38% of adults are prescribed three or more medications

Economic Impacts
- up to 40% of high users of mental health services have BPD
- over 50% of people are severely impaired in employability
- BPD is implicated in 17% of the prison population
- 38% of those with BPD have substance abuse/dependence disorders

Growing Support and Awareness
NAMI raises BPD to one of its priority populations in March 2006
Congressional Luncheon Briefing on BPD, May 8, 2007
U.S. House of Representatives unanimously passes House Resolution 1005 on April 1, 2008, designating May as Borderline Personality Disorder Awareness Month
Congressional Luncheon Briefing on BPD, May 19, 2010
Well-known individuals are finally coming forth to help build awareness and bring hope

Recommended Resources

U.S. Organizations
National Education Alliance for Borderline Personality Disorder
BPD conferences, publications, videos and education
www.neabpd.org or E-mail: neabpd@aol.com

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

Treatment And Research Advancements (TARA)
National Association for Personality Disorders
www.tara4bpd.org

Behavioral Technology LLC
DBT referral, training and resources
www.behavioraltc.org or E-mail: information@behavioraltc.org

National Institute of Mental Health (NIMH)
www.nimh.nih.gov

Books

Overcoming Borderline Personality Disorder: A Family Guide for Healing and Change
Author: Valerie Porr

The High-Conflict Couple: A Dialectical Behavior Therapy Guide to Finding Peace, Intimacy and Validation
Author: Alan Fruzzetti, Ph. D.

The Borderline Personality Disorder Survival Guide: Everything You Need to Know About Living With BPD
Author: Alex Chapman & Kim Gratz

Borderline Personality Disorder: Meeting the Challenges to Successful Treatment
Author: Perry Hoffman & Penny Steiner-Grossman

Helplines

Treatment And Research Advancements (TARA)
National Association for Personality Disorders
HELPLINE: (888) 4 - TARA

National Suicide Prevention Lifeline
(800) 273-TALK (8255)

National Hopeline Network
(800) - SUICIDE or (800) 784-2433

Crisis Center of Tampa Bay
Suicide & Crisis Hotline
(813) 234-1234

Information obtained from NEA BPD website fact sheet.
Our Mission

Inspired by my own journey to come to terms with a diagnosis of Borderline Personality Disorder in the summer of 2011, I want to devote myself to making a difference in the lives of others struggling to cope with this devastating disorder.

BPD AWARENESS OF TAMPA BAY is a nonprofit organization dedicated to raising awareness for Borderline Personality Disorder. We are not only hoping to support our community, but would like to offer our support as far as our words can soar.

Our mission is to advocate for Borderline Personality Disorder. Helping to bring awareness to the forefront by spreading the word to others about this serious illness that affects millions of people. To educate people with the true facts on this disorder in order to break down the unfortunate stigmas commonly associated with this disorder. To enlighten others with the knowledge that BPD is a treatable disorder and has a favorable prognosis with long-term treatment. We want to reach out to sufferers and their families by offering our support, the designation of resources and to share information that is helpful to them on understanding and coping with BPD. By bridging the gaps between sufferers, family and friends, support groups and the public we can work to achieve these goals one person at a time. We want to thank you for your support in helping us to change the face and the future of this disorder for a life worth living.

For more information
Visit our website at www.wix.com/bpdtampabay/home
Visit our community page at www.facebook.com/bpdtampabay

BPD 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:

- Frantic efforts to avoid real or imagined abandonment.
- A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.

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- Identity disturbance: markedly and persistently unstable self-image or sense of self.
- 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.
- Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
- 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).
- Chronic feelings of emptiness.
- Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
- 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 10 classified personality disorders and of those, Borderline Personality Disorder (BPD) is the most common, most complex, most studied, and certainly one of the most devastating, with up to 10% of those diagnosed committing suicide. BPD exists in approximately 2-4% of the general population; up to 20% of all psychiatric inpatients and 15% of all outpatients. Females predominate (about 75%) within psychiatric settings while males are more common in substance abuse or forensic settings.

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 xе “personality disorder” 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 diagnosis is underused.

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This owes mainly to the fact that BPD patients are difficult to treat and often evoke feelings of anger and frustration in the people trying to help. Such negative associations have caused many professionals to be unwilling to make the diagnosis. Many give precedence to co-occurring conditions such as depression, bipolar disorder, substance abuse, anxiety disorders and eating disorders. This problem has been aggravated by the lack of appropriate insurance coverage for the extended psychosocial treatments that BPD usually requires.

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.

Suicidality & Self Harm Behavior

The most dangerous and fear-inducing features of Borderline Personality Disorder are the self-harm behavior and potential for suicide. While 8-10% of the individuals with Borderline Personality Disorder commit suicide, suicidal ideation (thinking and fantasizing about suicide) is pervasive in the borderline population. 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 can result in physical scarring, and even disabling physical handicaps. 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 unprotected sex, driving under the influence, or binging and purging. Tattoos or pornography with retrospective shame are new variations of this.

Data obtained from “A BPD Brief” written by John G. Gunderson, MD