Insights into Borderline Personality Disorder Neurobiological Research and Clinical Interventions

Goldwurm Auditorium The Mount Sinai School of Medicine

PROGRAM

Sunday, October 21, 2007

8:00 am Registration and coffee

Moderator: Kenneth R. Silk, MD

8:30-9:00 ***Transference-Focused Psychotherapy***
Frank Yeomans, MD, PhD

9:00-9:30 ***Dialectical Behavior Therapy*** Alan Fruzzetti, PhD

9:30-10:00 ***Schema-Focused Therapy*** Jeffrey Young, PhD

10:00-10:15 Break

10:15-11:30 ***Clinical Roundtable: The Three Faces of Psychotherapy for BPD Clinical Perspectives***
Overview and Moderator: Kenneth R. Silk, MD
Discussants:
Alan Fruzzetti, PhD
Frank Yeomans, MD, PhD
Jeffrey Young, PhD

Facilitator: Alan E. Fruzzetti, PhD

11:30-12:00 ***Young Investigator Award***
Alexander L. Chapman, Ph.D., R.Psych

12:00-1:15 ***Family and Consumer Perspectives Panel***

1:15 Closing Remarks and Adjourn

CLINICAL ROUNDTABLE: THE THREE FACES OF PSYCHOTHERAPY FOR BPD CLINICAL PERSPECTIVES

OVERVIEW AND MODERATOR:
KENNETH R. SILK, MD

DISCUSSANTS:
ALAN FRUZZETTI, PHD
FRANK YEOMANS, MD, PHD
JEFFREY YOUNG, PHD

A CASE OF BORDERLINE PERSONALITY DISORDER

A Case of Borderline Personality Disorder

Acknowledgement:
We wish to thank Dr. Eric Simonsen and the Personality Disorders Section of the World Psychiatric Association for allowing us to use a section of this case. The case was prepared by Kate Davidson, Professor of Clinical psychology, University of Glasgow, UK.

The following case of borderline personality disorder is the basis of the discussion at the ***Clinical Roundtable: The Three Faces pf Psychotherapy for BPD Clinical Perspectives***

NOTES

Identifying data
The patient was a thirty-three year old woman who trained as a nurse, but at the time of referral was unemployed. She was initially seen by the community mental health team because of depression and self-harm and was referred for cognitive therapy because of her persistent self-harm and low mood, neither of which had responded well to antidepressant medication.

Presenting complaints
Complaints: self-mutilation, low mood, hopelessness, difficulty with relationships. Had difficulties with staff of community mental health team and had made an official complaint against a member of staff.

History of presenting complaints
Jane initially took an overdose of her mother's tablets at age fourteen when she felt unable to cope with social situations at school and her family situation. Following the overdose, she was referred to a child psychiatrist, but her parents decided that she should not attend the appointment. Jane thought that the main reason for this was that her parents were embarrassed by the overdose as both were professionals and known locally.

Over the next years of her adolescence, Jane began to cut herself with her father's razor and discovered that this relieved some of the tension she experienced. Her scars went undiscovered as she cut herself on her thighs and upper arms, parts of her body she never uncovered. During this time, Jane described frequent spells of low mood, but she sought no help. In her early twenties, following the end of a brief relationship, she took another dose of paracetamol. Following admission to Accident and Emergency, she was referred to a psychiatrist. He diagnosed depression and began treating her with antidepressants.

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She found these relatively helpful at first, but gained a significant amount of weight, adding to her feelings of worthlessness and self disgust.

Between the ages of twenty-four and thirty-three she had taken a further three overdoses, two of which had required medical treatment. Her liver was now damaged as a result of the paracetamol overdose. She had been treated with antidepressants off and on for over ten years when she was referred for cognitive therapy. Her diagnosis was changed to one of Borderline Personality Disorder at the age of twenty-eight.

Mental status

Jane presented as a medium height, overweight woman who looked older than her thirty-three years. Although she seemed withdrawn or shy at first, she became quite angry and hostile, then tearful and remorseful during the same session. Her mood was changeable, but overall appeared to be low. Her thinking was clear and she gave a coherent account of herself.

Family and social history

There was no definite history of mental illness in the family. Her mother was still alive, aged seventy, and was described as being critical and overbearing, particularly towards the patient. Her father was described as having been quiet and rather weak, allowing her mother to dominate. Both parents were nurses and worked full time when she was young. Her father had been in a relatively senior management post when he died of a heart attack, aged fifty-seven. The family lived in a small, modest house in an estate near the local hospital. The family was Catholic and church going was regular.

At the age of fourteen, she took an overdose. She felt she was unpopular at school due to being teased by her classmates for being overweight and unattractive. Her mother also put pressure on her to be slim "like her other sisters" and her father was disapproving of her lack of interest in her studies and impatient about her difficulties at school. Jane thought she was different from other girls at school, a fact that was emphasized by her mother repeatedly commenting to her that other girls were going out with boys when they should be home studying. Both her parents compared Jane to her older sisters and brother who were thought of as being more able students, good at sports, and popular. She said she felt miserable as an adolescent as there was often tension at home when she was a child as her parents argued a lot.

She tried to gain her mother's affection by carrying out household duties, but was only given more chores as a result. She felt unappreciated and used by her parents. Her mother preferred the children to come straight home from school and discouraged extra curricular activities, except those involving church activities. Although Jane had no close friends at school, she had some friends though a church group she attended.

According to Jane, her early development was normal though she thought she was not as academically able as her older sisters and brother. She had difficulty with arithmetic and spelling at school and had to have extra tuition for these subjects in primary school. She struggled academically at secondary school, but completed her education at age seventeen with just enough exam passes to get entry into nursing college. She was unsure about her decision to become a nurse but wanted her parents' approval and as they were both nurses she chose this option.

Her years at nursing college were among her happiest. She was able to excel in the practical ward-based work and coped reasonably well with her studies. She lived in the nurses' accommodation and, for the first time, was able to make friends through work. She had no boyfriends until she formed a relationship with a foreign doctor whom she did not know was married. This was her first and only sexual relationship. She ended the relationship when she realized he was married. She felt used by him and took a serious overdose with the intention of killing herself because she thought she would never be able to develop enough trust to form another relationship. She stole the medication that she took in overdose from her workplace and when this was discovered she was disciplined and charged with theft. She resigned from her training at this point and never worked again. She was referred to psychiatry at this point.

Jane has two older married sisters, both of whom were teachers and lived locally. One of her sisters has two daughters. Her older brother was divorced, worked in sales, and lived in another part of the country.

She is currently unemployed and on a low income.

Medical history

Birth and early development were normal. The patient had liver damage as a result of paracetamol overdose. She was obese and complained of stiffness and sore joints.

TRANSFERENCE-FOCUSED PSYCHOTHERAPY (TFP): AIM FOR CHANGE IN PSYCHOLOGICAL STRUCTURE

FRANK YEOMANS, M.D., PH.D.

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WEILL SCHOOL OF MEDICINE AT CORNELL UNIVERSITY

Bio

Dr. Yeomans is Clinical Associate Professor of Psychiatry at the Weill Medical College of Cornell University, Director of Training at the Personality Disorders Institute of Weill-Cornell, Lecturer in Psychiatry at the Columbia University Center for Psychoanalytic Training and Research, and Director of the Personality Studies Institute.

Dr. Yeomans' primary interests are the development, investigation, teaching, and practice of psychotherapy for personality disorders. He has helped establish training programs for psychodynamic therapy of personality disorders internationally. He has authored and co-authored numerous articles and books, including *A Primer on Transference-Focused Psychotherapy for the Borderline Patient* and *Psychotherapy for Borderline Personality*, co-authored with Drs. John Clarkin and Otto Kernberg.

Objectives

To understand:

- the concept of split psychological structure
- its relation to the symptoms of BPD
- the concept of identity integration and its role in the treatment of BPD

Summary of Transference-Focused Psychotherapy (TFP)

Frank Yeomans, M.D., Ph.D.

TFP is an evidence-based treatment designed specifically for patients with personality disorders. This twice-per-week individual therapy is based on psychodynamic concepts, including the idea that conflicts within the mind play a large role in the development of specific symptoms. The therapy is described in a treatment manual. TFP combines many of the elements in the Guidelines for the Treatment of Borderline Personality issued by the American Psychiatric Association. For example, TFP places special emphasis on the assessment and on the treatment contract and frame. This part of the treatment has a behavioral quality in that parameters are established to deal with the likely threats that may occur both to the patient's well-being and to the treatment. The patient is engaged as a collaborator in setting up these parameters. In addition, TFP may be combined with medication or other ancillary treatments to maximize the effect.

A core feature of TFP is the approach to a deep psychological structure that underlies the specific symptoms of BPD. The focus of treatment is on a fundamental split in the patient's mind that divides the patient's internal representations of self and others into extremes of bad and good. This internal split determines the way the patient perceives and experiences himself and the world around him. It underlies the patient's chaotic and unsatisfactory way of experiencing self, others and the environment, and it leads to the symptoms of BPD, such as stormy interpersonal relations and impulsive self-destructive behaviors.

After the behaviors typical of borderline pathology are contained through structure and limit setting, the elements of this split psychological structure are observed and analyzed as they unfold in the transference [the relation with the therapist as perceived by the patient]. The therapist can help the patient become aware of emotional aspects of herself or himself that previously were channeled in to acting out behaviors without full conscious awareness of the related affects and

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cognitions. As the patient gets to know all the elements of his internal world more fully, he or she can begin to understand the anxieties that have kept the elements split off from one another and can bring them together in an integrated and coherent sense of self. The establishment of this clear and solid identity allows the patient to achieve more flexible, adaptive, and satisfying functioning in life. In addition to alleviating the symptoms of BPD, TFP has been shown to increase patients' capacity for reflective functioning, that is, their ability to appreciate the complexity of their own self and of others. The resolution of the split internal psychological structure and the establishment of an integrated identity can allow patients to move beyond the borderline condition and achieve the capacity for fulfillment in work and love.

10/9/07

DIALECTICAL BEHAVIOR THERAPY

ALAN E. FRUZZETTI, PHD

RESEARCH DIRECTOR,
NATIONAL EDUCATION ALLIANCE FOR
BORDERLINE PERSONALITY DISORDER
ASSOCIATE PROFESSOR AND DIRECTOR,
DIALECTICAL BEHAVIOR THERAPY PROGRAM,
UNIVERSITY OF NEVADA, RENO

Bio

Alan E. Fruzzetti, Ph.D., is Associate Professor of Psychology and Director of the Dialectical Behavior Therapy and Research Program at the University of Nevada in Reno, Nevada, USA. This research and treatment program provides Dialectical Behavior Therapy for adults and adolescents with borderline personality and related disorders as well as comprehensive treatment services for couples, parents, and families.

Dr. Fruzzetti's research focuses on models of major psychopathology/severe behavior problems (e.g., borderline personality disorder, family aggression and violence, chronic depression) in the context of couples and families, and the development and evaluation of effective treatments for these problems. In particular, he focuses on the further development, evaluation and training of Dialectical Behavior Therapy (DBT) with individuals, couples, parents, and families for chronic or severe individual and/or family distress.

Dr. Fruzzetti is also Research Director and Member of the Board of Directors of the National Educational Alliance for Borderline Personality Disorder, and a co-developer of the Family Connections Program. He has provided extensive training in the United States, Europe, and Australia in DBT for individuals with borderline personality and related disorders, in Dialectical Behavior Therapy with Couples, Parents, and Families, in Family Connections, and in managing clients with multiple problems and reducing therapist burnout. He has authored or co-authored dozens of scholarly articles and book chapters on these and related topics, and a recent book on DBT for high conflict couples and families.

Dialectical Behavior Therapy

Dialectical Behavior Therapy (DBT) is an integrative treatment developed by Dr. Marsha Linehan and her colleagues at the University of Washington in the 1980s to treat people with multiple problems: borderline personality and related disorders (BPD), generally including self-harm, suicidality, depression, and other problems. DBT integrates or *synthesizes* the strategies and scope of acceptance-oriented therapies with the strategies and precision of behavioral and cognitive therapies and emotion science (Linehan, 1993). Dozens of controlled studies support the efficacy of DBT with BPD and related disorders in creating safety and stability while minimizing treatment drop-out, as well as resulting in significant improvements in mood, relationships, job functioning, etc. Largely due to stable outcomes, costs are significantly reduced also.

The model for the development and maintenance of BPD that is used in DBT views *emotion dysregulation* as the core of the disorder. Emotion dysregulation in turn increases behavioral dysregulation, cognitive dysregulation, and interpersonal dysregulation. Consequently, the common co-occurring problems of BPD (suicidal and non-suicidal self-injury, depression, anxiety, eating disorders, post-traumatic stress disorder, substance abuse, problems in relationships, etc.) are similarly understood either as dysfunctional (albeit briefly successful) attempts to regulate emotion or as natural consequences of chronic emotion dysregulation. The overarching goal of DBT is to help clients create lives worth living by helping them learn to regulate, or manage, their emotions. Much of the treatment is built around this principle.

Chronic and severe emotion dysregulation is hypothesized to result from an ongoing *transaction* between the patient's emotion vulnerability and ongoing invalidation from the social and family environment (Fruzzetti et al., 2005). Emotion vulnerability is influenced by both temperament and present biological disposition resulting from learning and present circumstances, and manifests as emotional sensitivity and reactivity, along with an often slow return to emotion equilibrium. Invalidation can take a variety of forms, from the obviously critical and emotionally abusive to well-meaning misunderstandings that occur because of temperamental differences and miscommunication between patient and family members.

DBT includes components to address 5 functions of treatment: 1) help patients learn new psychological and emotional skills [typically via skill training groups]; 2) help patients generalize those skills to their real, everyday lives [through detailed planning and between-session coaching]; 3) help patients enhance their motivation to replace over-learned, dysfunctional or otherwise painful behaviors with more skillful alternatives [individual psychotherapy]; 4) help patients manage their social and family environment to support progress [through family interventions or other social or administrative interventions]; and 5) provide ongoing support and skill building for therapists who treat multi-problem patients who have chronic and severe emotion dysregulation [via weekly team consultation meetings].

Learning key psychological and emotional skills are believed to be central in helping patients learn to regulate their emotions, build satisfying relationships, and thrive in their lives. These include skills to: 1) increase attention control and non-judgmental awareness [mindfulness]; 2) understand emotions, increase positive emotions, decrease vulnerability to negative reactions, accept negative emotional experiences, and change negative emotional experiences [emotion regulation skills]; improve relationships while balancing assertion with self-respect [interpersonal skills]; and 4) tolerate highly distressing experiences without doing things impulsively that increase dysregulation overall [distress tolerance skills].

Throughout DBT, the therapist (and others who interact with the patient) strives to understand and validate the primary emotional experience of the patient, along with other valid behaviors. In this therapeutic context, the therapist also targets dysfunctional behaviors for change, pushing the patient to substitute skillful alternatives for the problematic reactions and dysfunctional behaviors for which she or he sought treatment.

SCHEMA THERAPY

JEFFREY E. YOUNG, PHD.

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FOUNDING FELLOW OF THE ACADEMY OF COGNITIVE THERAPY

Bio

Dr. Young is the Founder of Schema Therapy. He is Director of the Schema Therapy Institute of New York, and is on the faculty in the Department of Psychiatry at Columbia University College of Physicians and Surgeons.

Dr. Young received his doctorate degree from the University of Pennsylvania, and then served as Director of Research and Training with Aaron Beck at the Center for Cognitive Therapy.

Dr. Young has lectured on cognitive and schema therapies internationally for over 20 years. He is widely acclaimed for his outstanding teaching skills, and was awarded the prestigious *NEEI Mental Health Educator of the Year* award. He has published widely in the fields of both cognitive and schema therapies, including two major books: *Schema Therapy: A Practitioner's Guide,* written for mental health professionals, and *Reinventing Your Life,* a popular self-help book based on schema therapy.

Description

Schema-Focused Therapy expands significantly on the proven principles of cognitive-behavioral therapy. The model draws on strategies from object relation, attachment and self theories, psychodynamic therapy and emotion-focused therapies. Schema therapy is especially well-suited to treating borderline personality disorder. Therapists use a three stage developmental approach that is flexible, yet direct and structured with therapists taking an active role in helping patients foster deep and far-reaching personality changes in their lives.

Schema therapy

Schema therapy is an integrative therapeutic approach, originally developed by Jeffrey Young, Ph.D., as an expansion of traditional cognitive-behavioral treatments. The schema approach draws from cognitive-behavior therapy, attachment theory, psychodynamic concepts, and emotion-focused therapies. In comparison to cognitive-behavioral therapy, schema therapy emphasizes lifelong patterns, affective change techniques, and the therapeutic relationship, with special emphasis on limited reparenting.

Schema therapy is particularly well-suited for difficult, resistant clients with entrenched, chronic psychological disorders, including personality disorders (especially BPD and narcissism), eating disorders, intractable couples problem, and for criminal offenders. It is also effective for relapse prevention in depression, anxiety, and substance abuse.

The latest developments in schema therapy are based on the schema mode approach, which places major emphasis on the role of unmet childhood needs, and the resulting schema-driven, self-defeating life patterns, cognitions, interpersonal and emotional difficulties that underlie personality disorders.

The concept of *schema modes* -- similar to mood or ego states -- is central to the understanding of Borderline Personality Disorder. This model hypothesizes that patients with BPD flip rapidly among four modes: the Detached Protector, Abandoned Child, Angry Child, and Punitive Parent. Some of the major treatment techniques for these modes includes "limited reparenting," emotion-focused imagery, mode dialogues, and "empathic confrontation."

The initial results of a major controlled outcome study have shown schema therapy to be highly effective for a high percentage of outpatients with Borderline Personality Disorder, with a low dropout rate.

EMOTION REGULATION AND BORDERLINE PERSONALITY DISORDER: LABORATORY AND EXPERIENCE SAMPLING RESEARCH

ALEXANDER L. CHAPMAN, PHD, R.PSYCH

ASSISTANT PROFESSOR
SIMON FRASER UNIVERSITY
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Bio

Dr. Alex Chapman is an Assistant Professor in the Department of Psychology at Simon Fraser University. His research focuses on borderline personality disorder and emotion regulation problems, self-harm, and impulsivity, and includes clinical research on DBT. Dr. Chapman received his B.A. in psychology from the University of British Columbia and his M.S. and Ph.D.
in clinical psychology from Idaho State University (APA-accredited). After an internship at Duke University Medical Center, Dr. Chapman completed a post-doctoral fellowship with Dr. Marsha Linehan at the University of Washington. He regularly gives workshops on DBT and consults with clinicians in both Canada and the U.S. Dr. Chapman has published numerous journal articles and book chapters and has given over 70 presentations on borderline personality disorder, self-harm, suicidal behavior, and DBT, among other topics. He has authored a book on borderline personality disorder (release:
December 2007, The Borderline Personality Disorder Survival Guide), as well as a book on behavior therapy that will come out in November 2007. In addition, Dr. Chapman is President of the DBT Centre of Vancouver (www.dbtvancouver.com), a treatment center for persons who struggle with BPD and related problems.

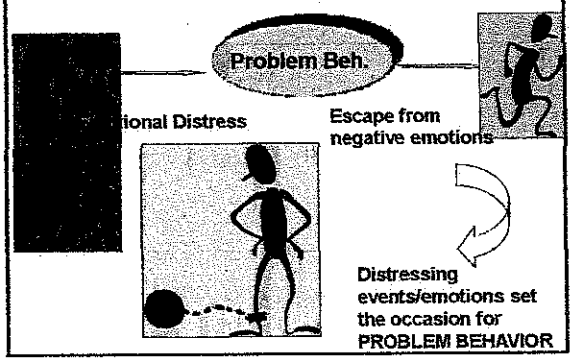
Emotion Regulation and BPD: Laboratory and Experience Sampling Research

Alexander L. Chapman, Ph.D.
Simon Fraser University

Emotion Regulation and BPD

- Difficulty regulating emotions is considered central to BPD (e.g., Linehan, 1993).
  - Gratz et al. (2006):
    - Lower willingness to persist despite distress in pursuing a goal.
  - Chapman et al. (in press):
    - Higher scores (even controlling for psychopathology) on all scales of the Difficulties in Emotion Regulation Scale except emotional awareness.
    - Impulsivity on a laboratory task that involves learning from punishment.

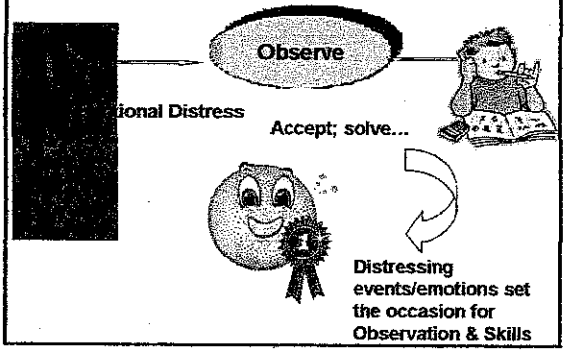
Avoidance/Escape



Emotion Regulation and BPD

- Chapman et al. (2005)
  - Female inmates (N = 105); 35% with BPD
  - BPD associated with avoidance, thought suppression, and avoidant coping
  - Thought suppression associated with self-harm among BPD, but not non-BPD participants.
- Others
  - (Bijttebier & Vertommen, 1999; Cheavens et al., 2005; Rosenthal et al., 2005; 2007; Vollrath et al., 1998)

An Alternative… Observe/Accept



Emotion Regulation and BPD

- Acceptance / Emotion Observation is a viable alternative
  - Interrupt impulsive action & facilitate exposure (Lynch et al., 2006).
  - Efficacy of DBT (review: Robins & Chapman, 2004).
  - Questionnaire studies
  - Experimental research
    - Levitt et al. (2004)
    - Feldner et al. (2003)

Emotion Regulation and BPD

- We need "real world" research on the direct effects of emotion regulation.
  - Experience sampling studies
  - 3 studies specifically on BPD (Links et al., 2007; Stiglmayr et al. 2001; 2005)
  - No published study has involved manipulating emotion regulation strategies

The Present Research

- Directly examine the effects of emotion suppression versus emotion observation in the natural environment.
  - Analogue BPD sample (to start with)
  - Scores > 38 (high-BPD) or < 23 (low-BPD) on the Personality Assessment Inventory
  - n = 39 low-BPD; n = 30 high-BPD
  - Majority female (80%), Chinese Canadian (46.4%), and White (33.3%)

The Present Research

- Experience sampling procedures
  - Four days of monitoring emotions, urges, behaviours 8x/day via PDA.
  - Random assignment: start on Thurs or Sat.

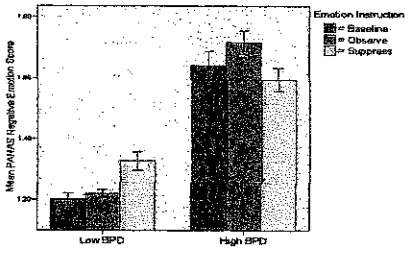
Day 1: Baseline	Day 2: Observe	Day 3: Suppress	Day 4: Observe

The Present Research

- Feasibility Data
  - 95% reportedly understood the instructions very well.
  - Participants responded to a mean of > 80% of beeps.
  - Mean response time = 6 seconds.
- Outcomes Assessed
  - Positive & Negative Emotions (PANAS: Watson et al. 1988)
  - Urges
  - Behaviors: self-harm, drug use, bingeing, etc.
  - Analyses: mixed-model ANOVAs, Bonferroni.

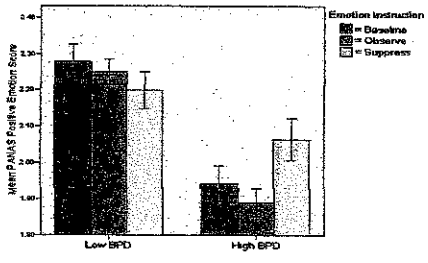
Results

- Negative Emotions, $F_{BPDxER} = 5.82^{**}$



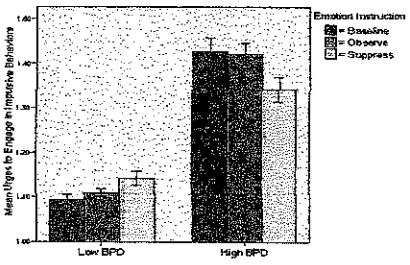
Results

- Positive Emotions, $F_{BPDxER} = 3.21^{*}$



Results

- Urges, $F_{BPDxER} = 5.69^{**}$



Summary

- *Primary findings*
  - Emotion suppression – higher negative emotions for low-BPD but not high-BPD participants.
  - Emotion suppression – higher positive emotions for high-BPD but not low-BPD participants.
  - Emotion suppression – lower urges for high-BPD but not for low-BPD participants.

Results

- Secondary findings
  - Higher negative emotions, $F = 61.87^{**}$
  - Higher urges, $F = 90.41^{**}$
  - Stronger association of negative contexts with urges ($d = .70$ vs. .35) and negative emotions ($d = .63$ vs. .27) (preliminary analyses)

Discussion

- *Was it Distraction?*
  - No, high-BPD participants distracted more than did low-BPD participants, but not just on the suppress day.
- Was it pre-existing psychopathology or avoidance?
  - No, after controlling for these factors, findings remained the same.

Discussion

- Length of time?
- Psychophysiology?
- Order?
- *Asking effective copers to suppress may* have negative effects.
- High-BPD individuals may report greater avoidance because it works for them! (also, with self-harm; Chapman & Dixon-Gordon, 2007)

The Next Step...

- *Clinical sample (n = 56 BPD, 56 controls,* 56 psychiatric controls)
- 4 weeks per condition
- Random assignment to two orders (B-O-S-B vs. B-S-O-B)
- Psychophysiology measures
- "Teach" skills as would happen in tx.
- Mechanisms of action in daily life.

PARENTAL VIEWPOINT ON THE DEVELOPMENT OF BPD: PRELIMINARY SURVEY FINDINGS

MARIANNE GOODMAN, MD

ASSOCIATE PROFESSOR OF PSYCHIATRY
DIRECTOR OF THE MOOD AND PERSONALITY DISORDER RESEARCH DIALECTICAL BEHAVIOR THERAPY PROGRAM
MOUNT SINAI MEDICAL SCHOOL

Bio

Marianne Goodman MD is an Associate Professor of Psychiatry and Director of the Mood and Personality Disorder Research Dialectical Behavior Therapy (DBT) Program at the Mount Sinai School of Medicine. She trained at the University of California, San Francisco (UCSF) and has spent her academic career at Cornell University and the Mount Sinai School of Medicine.

Currently, she collaborates with Drs. Siever, New and Koenigsberg on neurobiological studies of BPD, but her research focuses on the biological effect of DBT treatment. She is a recent recipient of an Advanced VA Career Development Research Award for the study of anger and aggression in borderline personality disorder. Additional research interests include adolescent borderline personality disorder and the identification of youth at high-risk for BPD.

Abstract

Parental Viewpoints on the Development of Borderline Personality Disorder - Preliminary Survey Findings

Marianne Goodman MD
Uday Patil MA
Elizabeth Diamond BA
Joseph Triebwasser MD

In efforts to identify precursors and high risk individuals for the development of borderline personality disorder (BPD), we sought to solicit opinions and viewpoints from parents with children diagnosed with borderline personality disorder. A Mount Sinai IRB approved anonymous survey, hosted on the NEA-BPD website was launched fall 2006. The survey contains approximately 100 questions for parents to complete on their BPD offspring and any unaffected siblings. The questions cover aspects of the child's life from pregnancy through young adulthood, family history, medical and treatment history, presence of BPD diagnostic criteria, parent burden and respondent demographics.

To date over 500 surveys have been completed with 300 having usable data. BPD offspring are identified by meeting diagnostic criteria embedded within the survey and having been given a diagnosis of BPD by a professional at some point in their life. Parents reported on 154 female BPD, 18 male BPD, 78 female unaffected siblings and 48 male unaffected siblings.

Preliminary results will be presented concerning average costs of treatment of BPD offspring, parent burden, satisfaction with care, developmental aspects associated with the BPD diagnosis and data on suicide and self-injury. Results pertaining to potential high risk developmental features of BPD include: 1) unusual sensitivity in infant girls, 2) sensitivity and moodiness in elementary school girls and boys, 3) few friends in elementary school girls 4) conflict with authority in elementary school boys 5) impulsivity, promiscuity and verbal outbursts in adolescent girls and 6) substance abuse and impulsive aggression in adolescent boys.

These data suggest that BPD prodromal features can be identified as early as infancy and affective instability is notable as early as elementary school. For BPD individuals, adolescent impulsivity is particularly problematic and manifests in high-risk behaviors such as suicide, self-injury, substance abuse in males and promiscuity in females. These preliminary results await replication with a larger data set.

➢ PARENTAL SURVEY AIMS

We were interested in obtaining parent's opinions regarding their children with BPD and unaffected siblings

In order to:

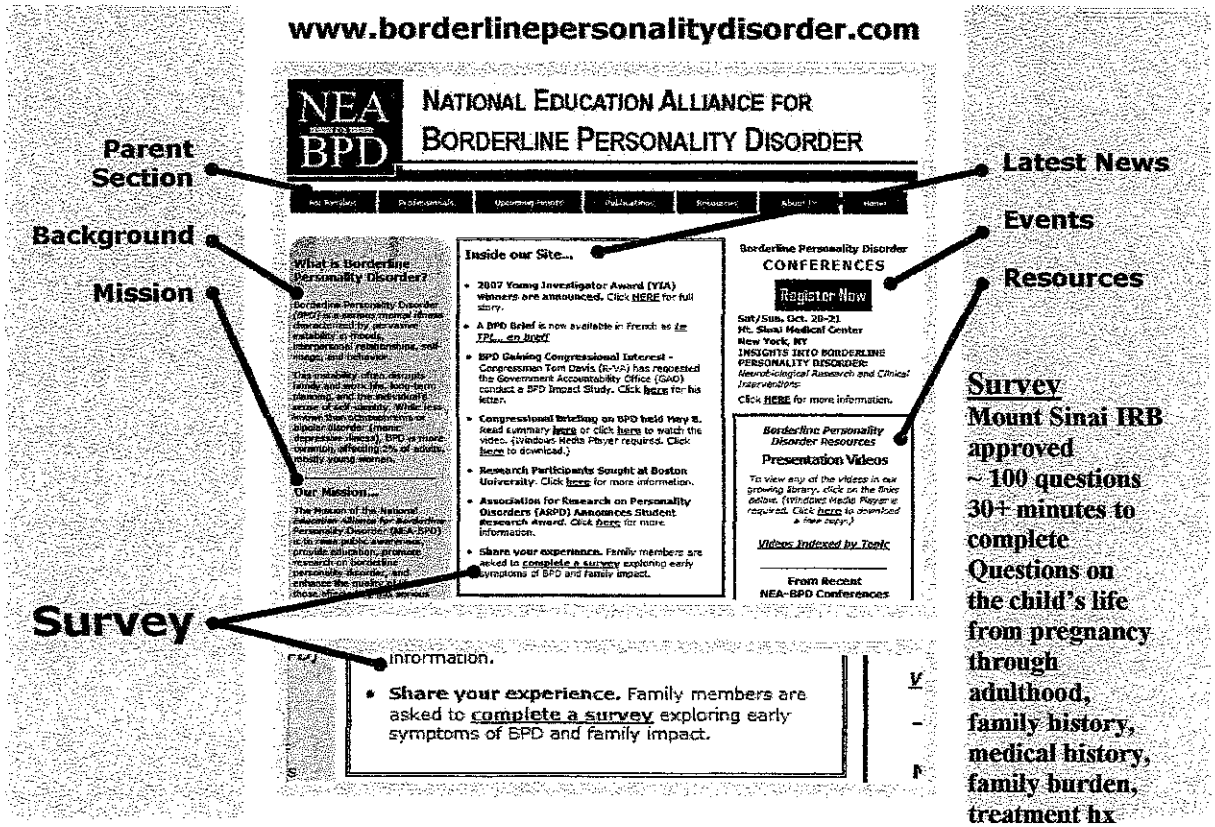
1) Identify early warning signs of BPD and predictors of who may develop BPD

2) *Describe the development of the disorder*

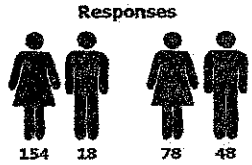
Future aim:
Identify high-risk children and adolescents & early features of the illness that can be targeted by ***preventive treatment***

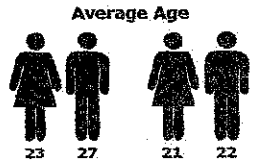
➢ NEA-BPD WEBSITE & SURVEY

Methods

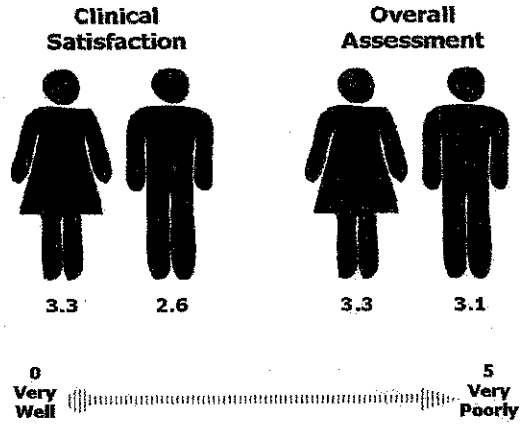


➢ SAMPLING FINDINGS





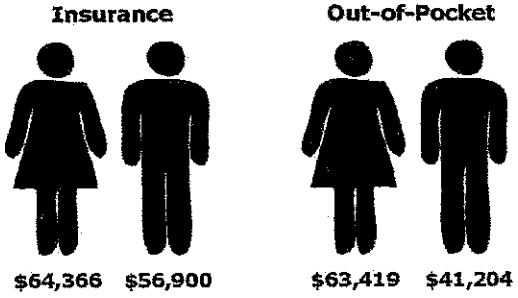
➢ ASSESSMENT & SATISFACTION FINDINGS



Clinical Satisfaction
How satisfied have you been with your interactions with this child's clinicians?

Overall Assessment
How would you say this child is doing overall?

➢ FINANCIAL BURDEN FINDINGS

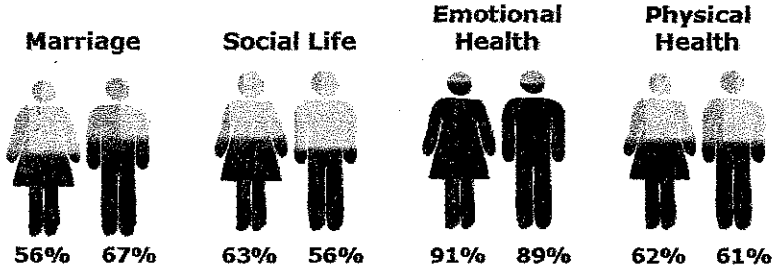


Insurance
How much money has your insurance company spent on this child's treatment?

Out-of-Pocket
What has been the financial cost to you and your family of his or her treatment to date?

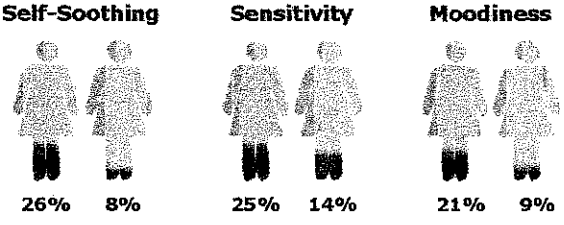
➢ PARENT BURDEN FINDINGS

Has this child's illness had a significant impact on your:



➢ INFANCY FINDINGS

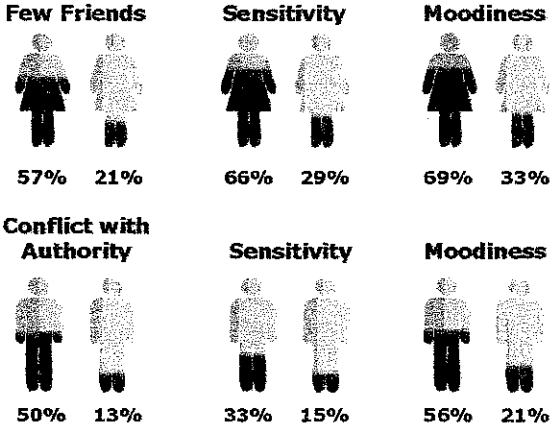
Did you notice anything unusual during infancy:



A **female** child showing unusual self-soothing, sensitivity, and moodiness is **9.2 times** more likely to acquire BPD than not acquire BPD.

➢ CHILDHOOD FINDINGS

Did you notice anything unusual during childhood



A **female** child showing all three is **9.1 times** more likely to get BPD.

A **male** child showing all three is **2.9 times** more likely to get BPD.

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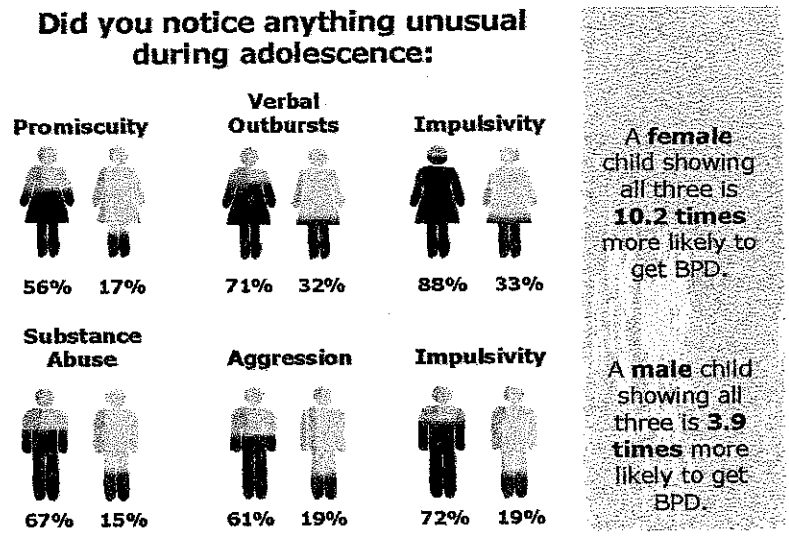
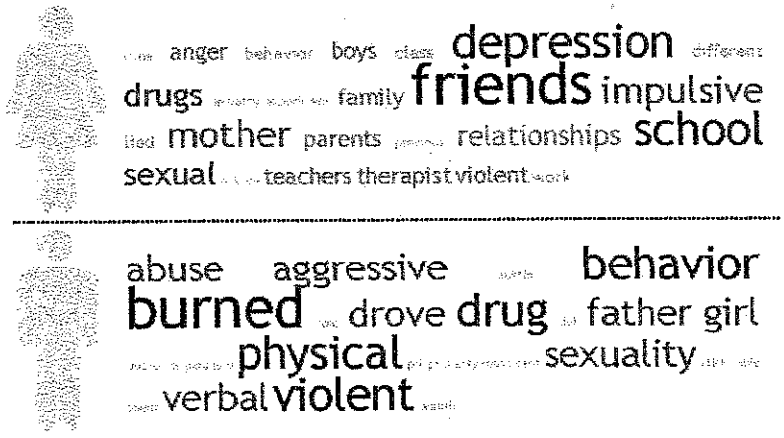
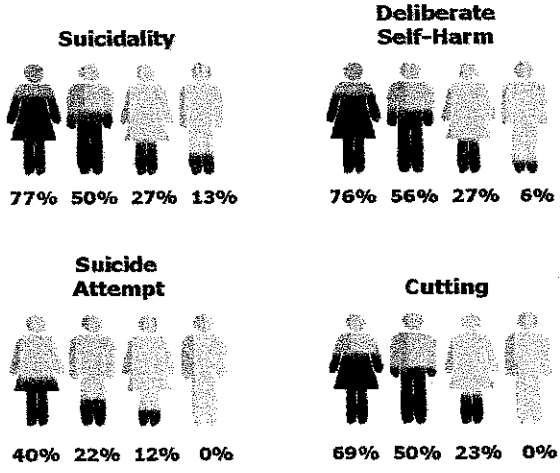
➢ ADOLESCENCE FINDINGS



➢ ADOLESCENCE TAG CLOUD



➢ SUICIDALITY & DELIBERATE SELF-HARM FINDINGS



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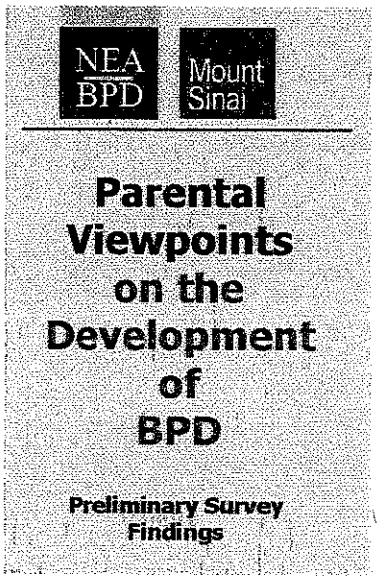
Joseph Triebwasser

...and the NEA-BPD for hosting the survey on their website

...and the hundreds of parents who have filled out the survey



We are still collecting data, so if you have not yet filled out the parent survey, please do!

NEA-BPD Website:
http://www.borderlinepersonalitydisorder.com

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