Friendly Link

Friends for Mental Health • Les Amis de la santé mentale

Borderline Personality Disorder

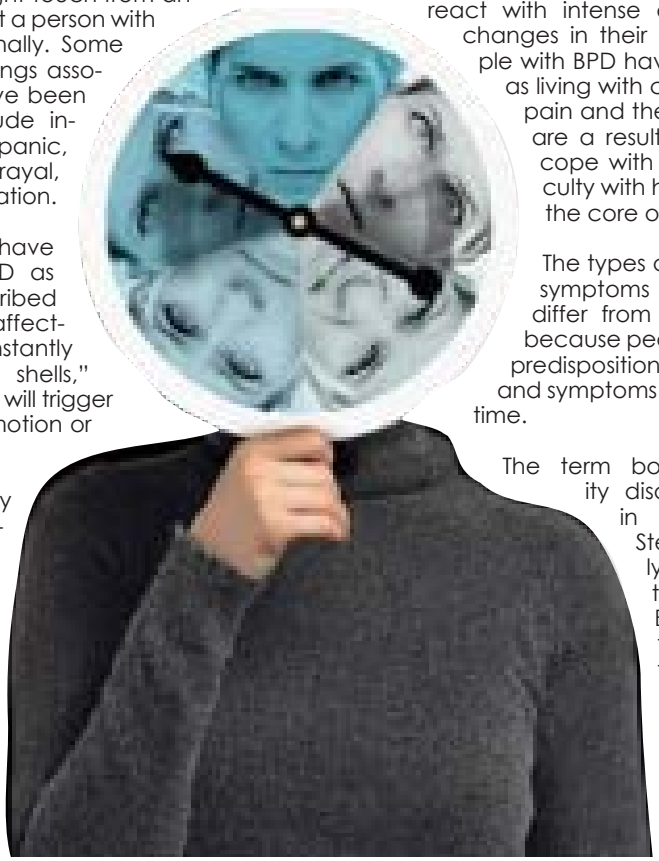
Source http://www.camh.ca

What is the Borderline Personality Disorder *(BPD)*?

Borderline personality disorder can have degrees of severity and intensity, but at its most severe and intense the emotional vulnerability of a person with BPD has been described as akin to a burn victim without skin. The tiniest change in a person's environment, such as a car horn, a perceived look, a light touch from another person, can set a person with BPD on fire emotionally. Some of the extreme feelings associated with BPD have been identified and include intense grief, terror, panic, abandonment, betrayal, agony, fury or humiliation.

Family members have feelings around BPD as well. They have described living with a person affected by BPD as constantly "walking on egg shells," never knowing what will trigger an outpouring of emotion or anger (DBTSF, 2006).

Family members may often feel manipulated by their loved one, but any perceived manipulation is not deliberate. The person living with BPD is trying to manage and deal with intense emotions that greatly affect his or her behaviour.



Borderline personality disorder (BPD) is a serious, long-lasting and complex mental health problem. Though it has received less attention than other serious mental health problems, such as bipolar disorder or schizophrenia, the number of people diagnosed with BPD is similar or higher than these disorders. People living with BPD have difficulty regulating or handling their emotions or controlling their impulses. They are highly sensitive to what is going on around them and can react with intense emotions to small changes in their environment. People with BPD have been described as living with constant emotional pain and the symptoms of BPD are a result of their efforts to cope with this pain. This difficulty with handling emotion is the core of BPD.

The types and severity of BPD symptoms experienced may differ from person to person because people have different predispositions and life histories, and symptoms can fluctuate over time.

The term borderline personality disorder was coined in 1938 by Adolph Stern, a psychoanalyst who viewed the symptoms of BPD as being on the borderline between psychosis and neurosis. However, some experts now feel the term does not accurately describe BPD symptoms and should be

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Association of **Families** and **Friends** of **People** with a **Mental Illness** *(West Island)*

33 years

750 Dawson Ave
Dorval Qc H9S1X1
(514) 636 - 6885
www.asmfmh.org
asmfmh@qc.aira.com

Copie en français disponible

Calendar

Invitation

Holiday Supper

Tuesday Decembre 9th, 6:30p.m.*

*Buy tickets before November 25th

Mundo trattoria

Trattoria Mundo
17003 Rte Transcanadienne,
Kirkland, QC H9H 5J1

Participation $5
Beverages(+tx + tip)
extra on site

SUPPORT GROUPS FOR CAREGIVERS*

PSYCHOSIS
(English & French)
Decembre 3rd, January 7th, February 4th
6:30 - 8:30 p.m.

BIPOLAR DISORDER
(English & French)
Decembre 17th, January 21st, February 18th
6:30 - 8:30 p.m.

BORDERLINE PERSONALITY DISORDER
(English & French)
Decembre 22rd, January 26th, February 23rd
6:30 - 8:30 p.m.

GROUPE FRANCOPHONE
(French)
Decembre 8th, January 12th, February 9th
6:30 - 8:30 p.m.

At Pierrefonds

GROUPE FRANCOPHONE*
(French)
January 29th, February 26th
6:30 - 8:30 p.m.

*** New ***

GRANDS-PARENTS SUPPORT GROUP
(English & French)

This monthly support group joins together individuals who not only have an adult child with a mental illness, but whom are also responsible for the care of their grandchildren due to the mental illness of the parent.
Grandparents often have the burden of coping with difficult behaviors and alienation from their own children as well as coping with being a primary caregiver to young children.
Wednesday, 10:00 a.m.- 12:00 p.m., Decembre 17th, January 21st, February 18th

TRAINING FOR CAREGIVERS*

BORDERLINE PERSONALITY DISORDER
(French; $20 for material)
The aim of this program is to educate families about this disorder - how it presents itself and what its challenges are.
Tuesday, 6:30 - 9:00 p.m.
January 20th - March 31st

TAKING CARE OF YOURSELF
(French)
Taking care of your own needs is not selfish - **it is a necessity**.
We will gain a better understanding of stress and how to reduce its effects as well as investigate how to increase our resilience and hapiness.
Thursday, 1:30 - 3:30 p.m.,
January 15th - February 12th

BIPOLAR DISORDER
(French; $20 for material)
11 week psychoeducational program.
Tuesday, 6:30 - 8:30 p.m.,
January 20th - March 31st

NAMI
(English)
The psychoeducational course by NAMI entitled Family-to-Family is a twelve week course dealing with all aspects of mental illness and is designed for caregivers who have a mentally ill loved one. The course is taught by specially trained family members and examines issues such as: the biology of the brain, critical periods and transitions in mental illnesses, how to communicate with the ill person, recovery and the fight against stigmatization, etc.
Monday, 7:00 - 9:30 p.m.,
January 19th - April 13th

Youth*

CHRISTMAS PARTY
FOR NAVIGATORS
(English and French)
For children who have completed the Anna workshops.
Friday, December 5th
5:00 - 8:00 p.m.

YOUTH SUPPORT GROUP 14-18 Y*
A support group for youth who have a parent or sibling with a mental illness. The group will focus on self-expression, social support, and healthy coping.
Tuesday 4:00 - 5:30 p.m.
December 16th
January 27th
February 24th

Pizza supper supplied!

ART THERAPY FOR ADULTS*
(English & French)
No artistic experience required.
Participation: $2 each workshop
Monday, 1:00 - 3:00 p.m.,
January 12th - March 30th

*** must register**

MUSEUM OUTING*
Van Gogh to Kandinsky: Impressionism to Expressionism 1900-1914
Visit of the collection followed with activity: 'Pastel Drawing'
Montreal Museum of Fine Arts
December 10th, 9:30 - 11:30 a.m.

Borderline Personality Disorder

Continued from page 1

changed. Some also feel that the existing name can reinforce the stigma already attached to BPD.

The road to specialized treatment and recovery is often hard because the symptoms of BPD can make the affected person emotionally demanding and difficult to engage and retain in treatment. As a result, the disorder is often stigmatized and helping services may be reluctant to accept clients with a BPD diagnosis.

However, with appropriate treatment, people with BPD can make significant life changes, though not all symptoms of BPD will disappear. Remission is more common as people reach the middle years of life. Hope and recovery are important to both the person and family members. "The overarching message of 'recovery' is that hope and meaningful life are possible. Hope is recognized as one of the most important determinants of recovery" (O'Grady & Skinner, 2007).

How common is BPD?

Studies in personality disorders are at an early stage of development. Community surveys of adults have indicated that the prevalence of BPD is close to one adult in 100, similar to that of schizophrenia (Paris, 2005). The most recent (and largest) community survey in the United States found a prevalence of BPD of six per cent. At this time, we don't have accurate rates for Canada (Grant et al., 2008).

It is unclear whether BPD is more common among women than men and some reports state that about 70 to 80 per cent diagnosed are women. Other research suggests that although there are more women in a treatment setting, there is no significant difference between the incidence of BPD in women and men (Grant et al., 2008).

What causes BPD?

As with other mental health disorders, our current understanding of BPD is that a person's genetic inheritance, biology and environmental experiences all contribute to the development of BPD. That is, a person is born with certain personality or temperamental characteristics because of the way their brain is "wired," and these characteristics are further shaped by their environmental experiences as they grow up and possibly by their cultural experiences.

Researchers have found differences in certain areas of the brain that might explain impulsive behaviour, emotional instability and the way people perceive events. As well, twin and family history studies have shown a genetic influence, with higher rates of BPD and/or other related mental health disorders among close family members. Environmental factors that may contribute to the development of BPD in vulnerable individuals include separation, neglect, abuse or other traumatic childhood events. However, families that provide a nurturing and caring environment may still have children who develop BPD, while children who experience appalling childhoods do not develop BPD.

Though histories of physical and sexual abuse are reported to be high among those with BPD, many other experiences can play a role for a child who is already emotionally vulnerable.
Stigma and BPD

Some therapists are reluctant to treat people with BPD because they are seen as being resistant to treatment and because of their emotionally demanding behaviour. Their tumultuous relationships, mood swings and suicidal gestures can provoke anger and frustration in the therapist. Some programs have formal or informal policies that refuse treatment to people with BPD. Advocacy groups have also identified lack of funding for research on BPD, and exclusion of BPD from research studies.

Sadly, people living with BPD often experience more stigma than people living with other mental health disorders. More information about understanding stigma, experiencing stigma, surviving stigma and combating stigma can be found in A Family Guide to Concurrent Disorders.

What feelings are associated with BPD?

Some common symptoms displayed by a person with BPD include:

- intense but short-lived bouts of anger, depression or anxiety
- emptiness associated with loneliness and neediness
- paranoid thoughts and dissociative states in which the mind or psyche "shuts off" painful thoughts or feelings
- self-image that can change depending on whom the person is with; this can make it difficult for the affected person to pursue his or her own long-term goals
- impulsive and harmful behaviours such as substance abuse, overeating, gambling or high-risk sexual behaviours
- non-suicidal self-injury such as cutting, burning with a cigarette or overdose that can bring relief from intense emotional pain (onset usually in early adolescence); up to 75 per cent of people with BPD self-injure one or more times
- suicide (about 10 per cent of people with BPD take their own lives)
- intense fear of being alone or of being abandoned, agitation with even brief separation from family, friends or therapist (because of difficulty to feel emotionally connected to someone who is not there)
- impulsive and emotionally volatile behaviours that may lead to the very abandonment and alienation that the person fears
- volatile and stormy interpersonal relationships with attitudes to others that can shift from idealization to anger and dislike (a result of black and white thinking that perceives people as all good or all bad).

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Borderline Personality Disorder

Recovery from *BPD*

Despite its often devastating effects on the affected person and his or her family, treatment outcome research has found that for **many people**, **treatment does work**. Many people with BPD do learn to **cope with their symptoms and do things differently**, particularly as they reach middle age.

Because of the serious and complex nature of their symptoms, people affected by BPD often require **long-term treatment**, often over several years.

Treatment accelerates the natural process of recovery. Studies have followed people affected by BPD for extended periods of time and found that most improve with time. About **75 per cent** will regain close to normal functioning by age **35 to 40** and **90 per cent** will recover **by age 50** (Paris, 2005).

It may take a longer time for a person with BPD to have a **remission of their symptoms** compared to people with other mental health problems, but when symptoms do decline, **remission seems stable with few relapses** compared to other serious mental health problems.

However, studies have also found that some BPD symptoms endure longer than others in some people. Some of the **more harmful behaviours** such as self-harm and suicidal behaviour decline while other symptoms such as feelings of abandonment and difficulty being alone may last longer.

Hope and recovery are important to both the person with BPD and his or her family members.

person, can set a person with BPD on fire emotionally. Some of the extreme feelings associated with BPD have been identified and include intense grief, terror, panic, abandonment, betrayal, agony, fury or humiliation. Family members have feelings around BPD as well. They have described living with a person affected by BPD as constantly "walking on egg shells," never knowing what will trigger an outpouring of emotion or anger (DBTSF, 2006). Family members may often feel manipulated by their loved one, but any perceived manipulation is not deliberate. The person living with BPD is trying to manage and deal with intense emotions that greatly affect his or her behaviour.

How is BPD diagnosed?

In Ontario, a physician, a psychiatrist or a registered psychologist can make a formal diagnosis of BPD or any other mental health disorder. The first step toward diagnosis is often with a family physician or the emergency department of a hospital. If there is enough reason to be concerned about someone's mental health, the family physician can make a referral for further assessment.

Whoever makes the diagnosis will use the DSM-IV-TR to ensure that the person fits the criteria for a diagnosis for BPD.

What other disorders co-occur with BPD?

It is very common for someone with borderline personality disorder to have other mental health problems that can complicate the diagnosis of BPD. Some disorders that commonly co-occur with BPD include major or moderate to mild depression, substance use disorders, eating disorders, problem gambling, posttraumatic stress disorder (PTSD), social phobia and bipolar (manic-depressive) disorder. Sometimes it can be difficult to diagnose BPD because the symptoms of the co-occurring disorder mimic or hide the symptoms of BPD. As well, relapse in one disorder may trigger a relapse in the other disorder.

When does BPD begin?

Like the onset of other serious mental health problems such as schizophrenia, the symptoms of BPD appear in late adolescence or early adulthood. In some cases, parents may have no warning that something is wrong; their child who had appeared to be functioning well suddenly falls apart with the onset of behaviours such as emotional outbursts and suicidal gestures.

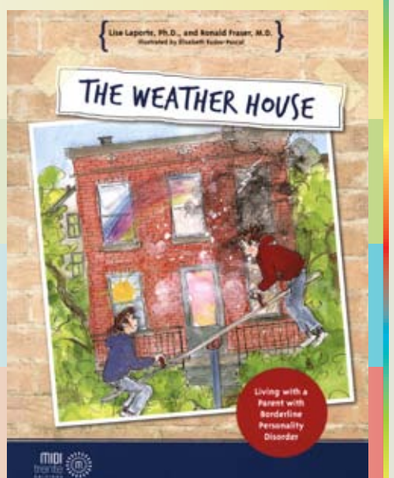
Special youth 6 to 12 years old

The Weather House is an illustrated book that provides, through its touching story, clinically sound and age-appropriate information for children, giving them clear answers to frequently asked questions about borderline personality disorder of a parent, and suggesting ways to cope with the situation.

Through weather pattern analogies, the book describes 2 days in the chaotic life of David and Mary. Psychoeducational comments are provided throughout the book by a "weather wiz" who explains, in simple manner, to both the characters and readers, the mother's sometimes strange behaviors that can be challenging to comprehend.

The book will help teach children take a certain distance, to better understand what is happening at home and how not to feel responsible for their parents' stormy moments.

*** Available at Friends' Library ***



Supporting the family member who has BPD

Source: http://www.camh.ca in Borderline personality disorder: An information guide for families. (© 2009 CAMH)

How can I support a person with BPD in seeking treatment?

Taking the steps to get help for a mental health problem can often seem overwhelming and frightening, even more so if the person has had distressing experiences in earlier contacts with the mental health treatment system. This is particularly true for people with BPD because of the complexity of their problems and the perception that they are "treatment resistant." As well, the person with BPD may not be able to see the value of treatment, particularly if prior treatment has not worked for them, and they may respond angrily or defensively to suggestions that they go for help.

Sometimes even asking for help can be difficult for someone whose culture does not encourage counselling or outside help. They may have difficulty finding the service they need because the counsel-ling is not available or when it is, it is not in their language. You could contact your local cultural group to find out about culturally specific services or request an interpreter to work with the available treatment services.

If a person also has a substance use problem or some other problem that is the responsibility of "another system," he or she may have been turned away and told to go elsewhere. Unfortunately in some communities, the mental health and substance abuse treatment systems are not well coordinated, but progress is being made in many communities to better integrate them.

In the past, it was felt that "confronting" a family member about his or her problems would induce the person to accept treatment. In fact it often had the opposite effect. We cannot make someone go for treatment if they do not want to, however, there are some steps you can take to support your affected family member if and when they are ready to consider treatment:

• **Learn about borderline personality disorder**. It is important to understand that your affected family member has a health problem as much as anyone with a physical health problem, and that the behaviours you are observing are the symptoms of this health problem. It is also helpful to understand that BPD is a result of the interaction between genetic, biological and environmental vulnerabilities, rather than behaviours that the person has developed as a result of their own actions or intentions. Useful print materials and websites are listed at the end of this booklet.
• **Find out about treatment resources** in your community. Talking to your family doctor can be a good place to start to find out what kind of assistance your family member needs and what is available. Other places to contact for help include psychiatric services at your local hospital, community mental health clinics, CLSC, health and social service agencies serving specific cultural or language groups, your spiritual leader or faith-based counselling services, or a counsellor with your workplace Employee Assistance Program.
You can also contact 811 or the crisis center (514) 684 6160.

• **Ask questions** like these to determine the best match to the needs of your affected family member:
1. Where is the facility located?
2. Is it community- or hospital-based?
3. Is the program outpatient, day or residential?
4. What are the admission criteria and how does your family member get referred to the facility?
5. What type and length of program(s) is offered? Is it a specialized treatment program for BPD?
6. What languages are services offered in? Are translation services available?
7. What levels of professional staff are employed by the facility?
8. Is there an aftercare or continuing care program?
9. What level of involvement is available to family members? Is there a program for family members?
10. If your affected family member has dependent children, is there any child care and/or programming available for children?
11. Is there a fee?
• **Assist** your family member to make an appointment.
• **Offer to accompany** her or him to the appointment if she or he would like your support.
• **Obtain** support for yourself either by attending a professionally run treatment/support program for family members or by attending a mutual-aid group. Education and support from others can help you in your relationship with your affected family member and may encourage him or her to seek help.
• **Take care of yourself** and encourage other family members to do the same.

Involuntary hospital admission

Family members often find it difficult to understand why their affected family member cannot always be involuntarily admitted to hospital for treatment so he or she can get the help needed. However, in Ontario and most other Canadian jurisdictions, a person can only be certified as an involuntary patient if a physician believes that he or she is likely to harm himself or herself (self-harming or suicidal) or someone else (violent) or suffer serious physical impairment (not eating, drinking, or taking required medications) due to a mental disorder. Under the Law P38, a person can be brought into hospital under the following three conditions:

• When a person is acting in a disorderly manner, the police are allowed to bring the person to be examined by a physician if they believe the person is a danger to himself or herself or others or the person cannot care for himself or herself.
• In situations where there is no immediate danger, anyone can bring evidence to a Quebec Judge that the person is a danger to himself or herself or others or cannot care for himself or herself and the judge can order that the person be examined by a physician. The judge is required to fill out a Psychiatric Evaluation Court Order that authorizes the police to take the person to a physician.
• If a physician has assessed a person within the last seven days and feels that a person may be a danger to himself or herself or to others or cannot care for himself or herself, the physician can order that the person be examined by a psychiatrist. The physician is required to fill out a Psychiatric Evaluation Court Order that authorizes the police to take the person for an examination.

Once the person is brought to a psychiatric facility, a physician may detain the person for up to 72 hours for psychiatric assessment, but no treatment is permitted without patient consent. After that time, a person must either be released or admitted as a voluntary or involuntary patient, as indicated in the Mental Health Act.

What to do in a crisis

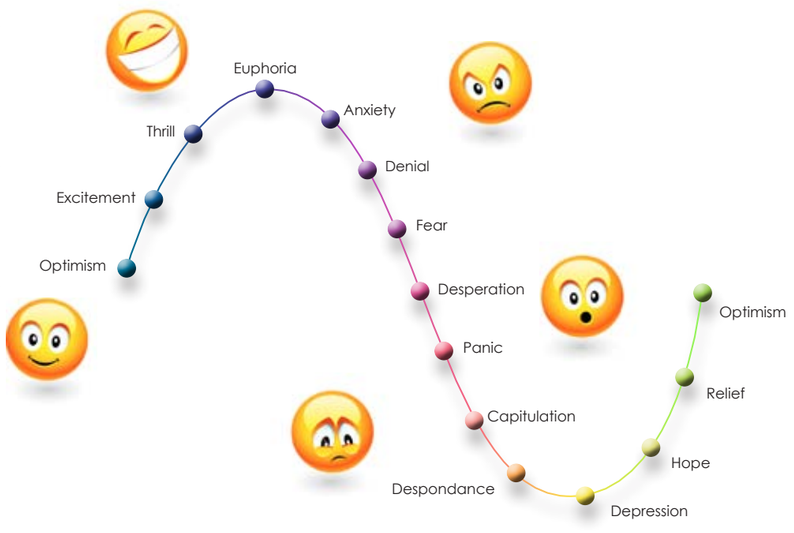
A Family Guide to Concurrent Disorders distinguishes between a crisis and an emergency. A crisis develops when "people feel they cannot control their feelings or behaviour and have trouble coping with the demands of day to day life." Potentially this can develop into outbursts of anger or violence or self-injuring behaviours. A crisis may develop slowly over a number of days or erupt suddenly.

Supporting the family member who has BPD

A particularly high-risk time for a crisis is when a person with BPD fears abandonment or loss of support. Such times may occur when a family member or a therapist is away for a period of time or when the person becomes fearful that the good progress they are making may lead to pressure to become more independent with consequent loss of support (Gunderson & Berkowitz).

Strategies for managing a crisis in the short term include:

• Stay calm and supportive of your family member. Do not get into a shouting match however difficult their behaviour, and even if you are hurt by what they are saying.
• Acknowledge what your affected family member may be feeling or saying, let him or her know you have heard them and are trying to understand what they may be feeling.
• Don't be afraid to ask about suicidal intentions. Suicidal behaviours can be an attempt to relieve emotional pain or communicate distress.
• Act on the agreed upon crisis plan if one is already in place.
• Support your affected family member in making telephone contact with their doctor, therapist or treatment program or offer to drive them to where they need to go (e.g., therapist, hospital).
• If your family member has broken any agreements you have with them regarding their behaviour, wait until the crisis is over to discuss it.



You should also make a long-term plan for managing a crisis:

• Discuss with your affected family member and his or her doctor or therapist the steps to take if a crisis should occur.
• Make sure that your affected family member is involved in all decisions regarding the crisis plan and that his or her wishes are respected.
• Create a crisis plan with your family member and others in the family as appropriate *(see our Safety Plan pamphlet)*
• The crisis plan can include a section on who does what, for example, who should accompany your family member to the hospital, and who should communicate with the treatment team.
• Include important information as part of your crisis plan, for example, telephone numbers for your family member's family doctor, therapist and local hospital, and a list of the medications he or she is taking.
• Keep the crisis plan in a prominent place.
• You may wish to include information from the crisis plan on a "crisis card" small enough for your affected family member to carry with her or him. The crisis card could also contain personal contact information, e.g., family member phone numbers, as well as a list of medications that he or she is taking and strategies to help them self-calm.
• Find out about crisis services in your community. If your family member is already known to the mental health system, you should ask whom you or your affected family member should contact if his or her behaviour deteriorates so this can be built into the crisis plan. Some communities have mobile crisis teams based at a local hospital psychiatric department who will come and assess the situation.

What to do in an emergency

Sometimes a crisis can escalate into an emergency. Emergencies could be situations in which there are threats of suicide, threats of physical violence, reduced judgment and decision-making or substance use that concerns you.

In some circumstances, your family member will voluntarily agree to talk to his or her doctor or therapist or to go to the hospital emergency department. In other situations, you may need to call 911. This can be a difficult step to take. Inevitably the arrival of the police or other emergency services will arouse the curiosity of neighbours. Both you and your affected family member may wish to keep his or her mental health problem as a private matter, but safety is a priority, particularly when it involves potential harm or suicidal intentions. If you perceive any danger to yourself or anyone else, do not hesitate to leave and call 911 from somewhere else. When you call 911, tell the operator that your family member needs emergency medical assistance, give the operator your family member's diagnosis and tell the operator that you need help transporting him or her to the hospital.

Depending on the kind of training your local police have had in handling mental health crisis situations, you may need to advocate on behalf of your family member. This may be particularly important if your family member is likely to react negatively to the presence of uniformed police. It is useful to write down the names, badge numbers and response times of the officers who respond to the call in case you have any concerns about the way the problem was handled.

When the emergency involves suicidality

Threatening suicide is one type of emergency situation. Threatening suicide or expressing a wish to die should always be taken seriously.
Some warning signs of suicide include:

• feelings of despair, pessimism, hopelessness, desperation
• recent self-injury behaviours
• withdrawal from social circles
• sleep problems
• increased use of alcohol or other drugs or overeating
• winding up affairs or giving away prized possessions
• threatening suicide or expressing a desire to die
• talking about "when I am gone"
• talking about voices that tell him or her to do something dangerous
• having a plan and the means to carry it out.

Sharing treatment information with family members

Generally speaking, sharing medical or treatment information about a person with others, either family members or outside health care providers or agencies, requires expressed consent. Consent in these situations would usually be written consent. Family members can play a key role in supporting change and developing newly acquired skills. However, some health care professionals are reluctant to involve or talk to family members, particularly if they perceive the family as "causing the problem." If your family member is still living at home and/or you are supporting them financially, you may feel you should have some moral right to be involved in their treatment. However, if your family member is capable of making treatment decisions, a health care professional will not be at liberty to share information without your affected family member's consent. This is achieved by having your family member sign a form in the doctor's office.

Some treatment programs offer family programming. This may involve family therapy sessions with the person affected by BPD and his or her family members. More commonly, family-specific education/support groups provide information about the disorder, ways for family members to support the person with BPD and strategies for family members' self care.

Family members can play an **important role** in **supporting their affected family member** to:

✶**manage their medication** by following **prescribing instructions**, and consult their physician or pharmacist if they have any **concerns**

✶determine whether their medication is **helpful** in **reducing unpleasant symptoms**

✶**discuss** their medication with their prescribing physician, its **effects** and **side-effects** and any **difficulties** they may be **experiencing**.

Consent to Treatment

Individuals have the right to consent to or refuse treatment, provided they are capable of doing so. Being capable means that the person is able to understand the information needed to make this decision and is also able to appreciate the reasonably foreseeable consequences of their consent to or refusal of treatment. There is no age requirement on consenting to treatment; if a person is capable, she or he gets to make her or his own treatment decisions, regardless of age.

Consent to treatment must be "informed" (which means that the person has been given all the requisite information and all questions related to the treatment have been answered), must be given voluntarily and must not be obtained through misrepresentation or fraud. In situations where a person is not capable to give informed consent, then a substitute decision-maker would be consulted for treatment consent. The HCCA (Health Care Consent Act) sets up a hierarchy of individuals who may provide substitute consent.

How to deal effectively with the legal system if a family member has a legal problem

There are support and diversion programs in many communities. The role of these programs is to provide advocacy and support for people with mental health problems and their family members when they are involved with courts, police or other legal situations. Diversion programs are intended to divert people with a mental health problem who have committed minor offences from the criminal justice system into treatment and community support.

The legal system can be a potentially frightening experience for a newcomer to Canada, particularly if they are not comfortable communicating in either English or French. Possible resources for advice and support might include an ethno-specific agency, a legal aid clinic experienced in serving newcomers to Canada, faith community leaders and cultural interpreter programs. *(see www.actionautonomie.qc.ca)*

Your family member may also be referred for an assessment and possible treatment at a forensic facility if she or he has been found either unfit to stand trial or not criminally responsible for an offence by reason of mental disorder.

How can I support my family member during treatment?

Treatment for BPD is a long-term endeavour, often requiring a commitment of a number of years. Progress is not always straight forward and there will be diversions along the way with relapse back to old behaviours in times of stress or crisis. Some guidelines suggested for helping your affected family member include:

• Support your affected family member in the treatment program by encouraging him or her to attend treatment, take the medication as prescribed and lead a healthy lifestyle by eating well, exercising, getting enough rest and remaining abstinent from substances if this is a problem area.
• Recognize that change can be stressful and difficult to achieve. Making progress in treatment, acquiring new skills, and becoming more independent can bring up fears that family members will start to withdraw protection and support and the person will be abandoned to manage on his or her own. These fears can lead to a relapse back to previous negative coping methods such as self-injury or a suicide attempt. It is important that family members support progress with words and encouragement that let their affected family member know they understand how difficult change is.
• Support your family member to set realistic goals, and to work on them one at a time, one step at a time.
Though you don't want to discourage your family member, it is very important to keep in mind the fine balance between a desire for independence and fears of abandonment. For example, a realistic goal might be enrolling in one university course for a semester rather than signing up for full-time classes; finding employment that he or she can manage or moving into a group home rather than moving out of the family home directly into independent living.
• Maintain a cool and calm environment when dealing with conflict or a crisis. It is important to recognize that some of the symptoms of BPD, including intense and painful emotions, inability to deal with even small separations from significant people, and black and white (all good, all bad) thinking about people or situations can easily lead to family conflict or a crisis. Take time to listen, or make a time later if you are unable to deal with it at that moment. The important thing is for your family member with BPD to be heard and validated.
• Remain optimistic, though change may be slow. The periods of time when symptoms are absent or much reduced will increase as your family member and you learn new skills for dealing with relapses.
• Most important, don't feel the responsibility is all yours to solve problems and be responsible. It is important to allow your affected family member to be in charge, try new behaviours and be responsible for negative behaviours.
• If you are concerned, contact your family doctor or your family member's treatment provider, or in emergency situations call 911.

Bell Let's Talk awards us $20 000 THANK YOU !!

Friends for Mental Health is pleased to be the recipient of a **$20,000 grant** from the **Bell Let's Talk Community Fund** to help fund its counseling and support program which helps family members of people suffering from mental illness.

At our Fall conference on October 27th, with ANEB, Dr. Doris Steinberg, President of our the Board of Directors, and Mrs Louise Laurier, Vice-President, received the plaque from Mrs Kathy Jahudka, Manager of Bell Community Investment.

Distinguished Mayors Edgar Rouleau (Dorval), Michael Gibson (Kirkland) and Dr. Bill Steinberg (Hampstead) honored us with their presence.

About a hundred people present! Thank you all!

The delicious buffet of l'Équipe Entreprise

The Board of Directors and the Mayors of Dorval, Kirkland and Hampstead

Montreal Walks for Mental Health

Over 1,200 walkers participated in this 6th edition on October 5th, including 15 members of Friends. Thank you for your involvement!

West Island Community Shares

Wednesday, October 8th, Friends have joined the 400 walkers to launch the 17th fundraiser campaign of West Island Community Shares.

This was an opportunity to highlight the amazing recurring support this organization provides us.

Thank you to our donors

We'd like to thank these organizations and foundations for their support this past quarter: **Bell Let's Talk, City of Kirkland, Minister Martin Coiteux, CN Community Fund, Echo Foundation, MNA Geoffrey Kelley, Pointe Claire Oldtimers**

Agence de la santé et des services sociaux de Montréal Québec

WEST ISLAND COMMUNITY SHARES

Centraide of Greater Montreal

MEMBRE DU RÉSEAU Avantdecraquer.com ORGANISME CERTIFIÉ FFAPAMM

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