## borderline personality disorder: Its' powerful role in the lives and suicides of people with BPD

V. Porr
*TARA for Borderline Personality Disorder TARA4BPD, EXec Director, NYC, USA*

Shame, a central emotion in borderline personality disorder (BPD), has been overlooked despite its' relationship to self-injurious behaviour, chronic suicidality, self-esteem, quality of life, and angry-hostile feelings. Patients describe shame when explaining acute feelings of emotional pain. There is a paucity of research exploring the impact of shame on the person with BPD's sense of self and behaviors. BPD symptoms may be the expression of and defenses against this painful emotion. Shame-proneness is related to anger arousal and the tendency to externalize attributions for one's own behavior by blaming others or not taking responsibility for one's behavior. The relationship between shame-proneness and BPD has important implications for treatment. TARA for BPD, an educational and advocacy organization, developed a Family Psycho-education program teaching how shame is often the common denominator of BPD responses, triggering escalations, emotional shifts, volatile reactions, anger and misperceptions. Shame is the response to perceived negative evaluations (judgment, criticism, or blame) and general misinterpretation of social situations. Shame is an impediment to thinking clearly, exaggerates ambiguity and overwhelms cognitive ability in the moment. As shame is often confused with guilt, raising awareness of shame responses is essential for improving family relationships. Families can learn to recognize shame responses and implement evidence based techniques from dialectic behavior therapy (DBT) and mentalization based therapy (MBT) to decrease its' impact on their loved one with BPD. Demonstration of methodology to address shame in family interactions and data from a TARA Internet survey of The Experience of Shame will be presented.

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## Stability of results of treatment and therapeutic compliance of patients with organic non-psychotic mental disorders

V. Rudnitsky [1,*], V.B. Nikitina [2], M.M. Axenov [1], N.P. Garganeeva [3], E.D. Schastnyy [4]
[1] *Mental Health Research Institute, Tomsk National Research Medical Center, Russian Academy of Sciences, Borderline States Department, Tomsk, Russia*
[2] *Mental Health Research Institute, Tomsk National Research Medical Center, Russian Academy of Sciences, Laboratory of Clinical Psychoneuroimmunology and Neurobiology, Tomsk, Russia*
[3] *Federal State Budgetary Educational Institution of High Education "Siberian State Medical University" of Ministry of Healthcare of Russian Federation, General Medical Practice and Polyclinic Therapy Department, Tomsk, Russia*
[4] *Mental Health Research Institute, Tomsk National Research Medical Center, Russian Academy of Sciences, Affective States Department, Tomsk, Russia*
* *Corresponding author.*

*Introduction* Non-psychotic mental disorders of organic register tend to have protracted progressive course, to respond poorly to treatment. Traditionally it is explained by features of cerebral-organic process. However, affective, behavioural and cognitive disturbances can be complicated by medico-social problems including treatment-related.

*Objective* To analyse efficiency and stability of results of the therapy of organic mental disorders and propose approaches and means of their improvement.

*Methods* Clinical-psychopathological, epidemiological, clinical-dynamic, catamnestic, experimental-psychological, medical statistics.

*Results* The most frequent causes of decompensations of organic mental disorders in patients with positive results of the therapy were analyzed. Sixty-four percent (58 patients) after 6 months showed partial recurrence of symptoms and after a year the condition practically returned to the initial one. However, only 12.22% (11 patients) passed recommended course of maintenance therapy to sufficiently full extent, 23.33% (21 persons) have discontinued it due to subjective causes during a month after discharge, about 2/3 of patients during the first two months of the therapy. Patients showed low indicators of therapeutic compliance, low level of therapeutic alliance, little familiarity with the illness and treatment and unrealistic expectations about prospects of the therapy. During insignificant difficulties in the therapy, it usually was discontinued and renewed during relapse of symptoms. A medico-social approach with support of psychotherapeutic and psycho-corrective work and information educational programs were developed.

*Conclusion* Proposed psychotherapeutic and educational approach heightens efficiency and stability of treatment and can serve a basis for further improvement of psychiatric, psychotherapeutic and medico-social assistance for patients with organic mental disorders.

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# e-Poster Viewing: Philosophy and psychiatry

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## Working with anxiety and depression from a Buddhism framework

A. Allen
*The ADHD Clinic, Psychiatry, Toronto, Canada*

Buddhism as a spiritual discipline is concerned with freedom from suffering, conceptualizing suffering as originating in false views about the nature of self and reality. Buddhist psychology conceptualizes emotions and mental habits as being wholesome or unwholesome based on the tendency of these habits to promote or hinder the quest for enlightenment, and contains a rich diversity of methods to transform unwholesome emotional tendencies. Many of these emotions, such as anger, fear, and despair, are commonly dealt with in clinical or therapy settings. Buddhist ideas about the genesis and cessation of suffering can be used as an overarching model to organize a diversity of therapeutic techniques, bridge different therapy models, and select particular techniques at particular times in the treatment of emotional disorders. Learning objectives: after this session, participants will be able to use the Buddhist Yogacara model of mind and karma as a model of how negative emotions are transformed. After this session, participants will be able to describe indirect methods (evoking wholesome feelings) in order to transform negative emotional tendencies and how this overlaps with current therapy models such as supportive and compassion-focused therapy. After the session, participants will be able to conceptualize how Buddhist "direct methods" of mindful awareness and contemplating right view overlaps with methods used in cognitive behavioural therapy, marital therapy, or acceptance and commitment therapy. Self-assessment questions: according to Buddhist psychology, what is the primary cause of neg-