

Care of the person with Borderline personality disorder in the community

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Abstract

The development of community-based models of care in New Zealand has led to dramatic changes in the treatment available for people with mental illnesses. However, we appear to be failing to provide comprehensive coordinated and continuous care for clients diagnosed with Borderline Personality Disorder (BPD). One major problem is the stigma and dread that many community mental health nurses equate with the care of people diagnosed with BPD, resulting in the care given being limited and fragmented. This article examines the trauma paradigm for viewing BPD and provides an overview of the knowledge and skills that are required to care for people diagnosed as having a borderline personality disorder within the community.

Introduction

Kaplan and Sadock (1991) define personality as both emotional and behavioural traits that characterise the person and state that personality is stable and predictable to some degree. Thus, a personality disorder is a deviation from the range of character traits that are considered “normal” for most people. When these traits are inflexible and maladaptive and the result is distress and impaired functioning they are considered to be a class of

personality disorder. Of the ten different personality disorders in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), one of the most controversial is Borderline Personality Disorder (BPD).

There is much debate around the definition and diagnosis of BPD (Shea, 1991). The term was first used in 1938 to refer to a group of disorders that lie between neuroses and psychoses (Greene and Ugarizza, 1995) but can also be used as a disparaging label for difficult clients (Reiser & Levenson, 1984). Some of the challenges in caring for clients with BPD relate to the symptoms and intense transference and counter-transference in the relationship between client and nurse/therapist (Gallop, 1985). This can result in nurses feeling frustrated, helpless, distant and even denying mental health services (Gabbard, 1991 cited in Greene & Ugarizza, 1995). A person with BPD is often seen as an impostor, who is in control of their behaviour but who chooses to be difficult and manipulative (Nehls & Diamond, 1993). Studies show that 77% of those diagnosed with BPD are women (Widiger & Weissman, 1991).

Aetiology

There are several explanations of the aetiology of BPD.

Biological factors

Greene and Ugarizza (1995) offer two biological explanations for BPD. The first focuses on neurotransmitter activity and systems, where an increase in dopamine action can account for transient psychotic states and decreased serotonin activity can account for irritability and impulsiveness. Lastly, an increase in the cholinergic pathways can lead to depression in clients with BPD. The second explanation puts forward organic brain dysfunction caused by trauma, epilepsy and attention deficit hyperactivity disorder (ADHD) as a cause of the increased impulsiveness, self-mutilation and affective disinhibition seen in BPD. However, Kaplan et al., (1991) argue a genetic link, proposing that people with BPD have more relatives with mood disorders than a control group and often have a mood disorder themselves as well.

Psychoanalytical factors

Another theory of the aetiology of BPD relates to the psychological birth of the human being or process of separation-individuation, which occurs, between birth and three years of age. In this process a sense of self is developed by the child, a permanent sense of significant others (object constancy) and the integration of both good and bad as part of the self concept (Mahler, Pine & Bergman, 1975). Mothering influences the outcome of the separation-individuation process but if this is inconsistent, insensitive or unattuned to a child's needs then dysfunction occurs (Westen, 1990). If a child's efforts to be autonomous are punished whilst dependent behaviour is rewarded, differentiation does not occur and responses such as intense anger, mood swings, dichotomous thinking and identity diffusion can result, all of which are seen in a person with BPD.

Childhood abuse/ Trauma

The trauma perspective is gaining increased recognition as studies show strong correlations between sexual or physical abuse in early childhood and the development of BPD (Paris, 1993). Herman (1992) argues that what is labelled BPD is a manifestation of post-traumatic stress disorder (PTSD), called "complex PTSD", which follows prolonged, repeated trauma resulting in personality changes (most prominently identity and relationship disturbance).

Biosocial factors

Linehan (1993) hypothesises that people diagnosed with BPD have a biological tendency to react more intensely to lower levels of stress than others and to take longer to recover. Linehan adds that often they were raised in invalidating environments and became uncertain of the truth of their own feelings. As adults a failure to master three basic dialectics means they go from one polarity to another.

Cultural issues

There is little literature to indicate that BPD occurs in other than Western cultures, despite the extensive research that has been done on BPD.

Assessment and diagnosis

As seen in the aetiology section above, the accuracy of the diagnosis of BPD is controversial. Most approaches to treatment define BPD according to DSM-IV using a descriptive objective approach (Shea, 1991). Some writers argue that this dominance of DSM-IV in psychiatric settings (as expert authority of behaviours outside the norm) means that a diagnosis pathologises behaviour (Crowe, 1997; Gallop, 1997). In this section the DSM-IV perspective and the trauma perspective are reviewed.

DSM-IV and the medical model

In this paradigm "Borderline personality disorder is described as a pervasive pattern of interpersonal relationships, self-image and affects and marked impulsivity" (Crowe, 1996, p106). It falls under the DSM-IV Axis II diagnostic category, cluster B (dramatic, emotional, erratic) and can be associated with co-morbidity of Axis I and II disorders (American Psychiatric Association, 1994). Diagnosis is problematic because of the fluctuating nature of symptoms and concerns that are presented by the client (Arntz, 1994).

In order to be diagnosed with BPD a person must meet five of nine criteria described in the DSM-IV (1994). These are around abandonment, unstable interpersonal relationships, identity disturbance, impulsivity, recurrent suicidal threats, gestures or behaviours, affective instability, chronic feelings of emptiness, inappropriate intense anger, transient stress-related paranoid ideation or severe dissociative symptoms. Skodol and Oldham (1992) recommended that 2-5 years is the minimum clinical time to indicate a stable personality pattern. Whilst Paris (1993) added that by middle age the majority of clients with BPD had recovered from acute symptoms and no longer met the criteria for BPD (Greene & Ugarriza, 1995).

Complex post traumatic stress disorder (PTSD)

The medical model paradigm of personality disorder is criticised by several researchers (Brown, 1992; Herman, 1992), who see the label as misleading and having negative effects on treatment. Herman warns that trying to fit people into the DSM-IV mould without addressing the underlying trauma or understanding what the problem is, results in fragmented care. Brown (1992)

agrees and suggests the distress of abuse resembles responses to experiences of interpersonal trauma rather than core personality pathology. Brown and Walker (1986) argue that a diagnosis that lies between personality disorders and PTSD that is framed situationally is more helpful as it can be changed rather than as personality which can not. This diagnosis acknowledges the effect of multiple exposures to trauma which must be adapted to daily for victims of trauma and interpersonal violence and varies from PTSD, which assumes a single exposure to trauma outside the range of everyday experience.

Gender bias and stigmatisation

Brown (1992) argues that androcentric gender role norms and stereotypes influence judgements of psychopathology, which result in more women than men being diagnosed with BPD and the stigmatisation by mental health professionals of gender role traits that are normative for women. Often the traits and behaviour considered dependent, passive, dysfunctional and pathological are appropriate and skilful ways of accessing some power in a context where more overt and appropriate expressions of power are stigmatised or penalised (Brown). The effects of sexism multiplied by the requirements for survival under abuse require an alternative frame of reference to viewing a person's symptoms. Further stigmatisation of certain behaviours occurs through having space for Axis II personality traits irrespective of whether they are at a psychopathological level. Brown adds that context and variables such as race, gender, class and experience of abuse or victimisation are not considered either. Brown (1992) and Gallop (1997) propose a feminist perspective for BPD that takes into account the meaning of interpersonal context and relatedness rather than separation and individuation.

Power dynamics

Brown and Gallop (1997) argue that the mental health setting often mirrors the interpersonal power dynamics where abuse occurred. The presence of a powerful other can exacerbate symptoms and vary from how someone presents in a more power-equal situation. Many non-exploitative situations would need to be experienced before patterns of survival were relinquished.

Age trauma occurred

Van der Kolk, Hostetler, Herron & Fisler (1994) suggest that up to a century ago, research showed traumatised people would have their personality development checked at whatever point the trauma occurred after which it could no longer be added to. The authors suggest trauma has different effects at different stages of development. If the trauma is experienced as an adult then it is more likely to become what is known in the DSM-IV as PTSD. However, if trauma is experienced at an earlier age, then different manifestations of developmental arrest will be seen, therefore a person traumatised at a particular age might process intense emotions later in life the way someone at that age would, using earlier developmental accomplishments. The earlier someone is traumatised, the more pervasive their psychological disability.

Ethical and legal issues

There are major ethical and legal issues to consider in caring for people with BPD in the community. An awareness of the Mental Health Act is vital and issues such as splitting and ambivalence can make the area of ethical and legal issues a minefield.

Suicide

People with BPD represent the highest risk of suicide of any of the personality disorders and factors such as “overplaying their hand” or being rescued unexpectedly make suicide risk difficult to ascertain (Stone, 1993). He suggests that the therapist/nurse can become skilled at predicting suicide risk through clinical experience, supervision and by becoming familiar with the literature on suicide risk. The exploration of specific individual techniques for controlling impulses, such as the desire to self-harm, to identify triggers and patterns and increase self-awareness can also be useful. Including such questions as “do you want to slash?”, “Do you want us to help you control slashing?” (Gallop, 1992). Respecting the autonomy of a client with BPD can be difficult if they are presenting with suicidal ideation and there is a requirement to assess the need for compulsory treatment.

Medico-legal issues

Gutheil (1985) makes several points in his article about medico-legal issues that can arise in the treatment of people with BPD. In respect of the Mental Health Act (1992) there can be a legal ignorance of BPD as some people present with excellent functioning whilst others appear too sick to be discharged from compulsory treatment. The effects of borderline psychodynamics such as borderline rage, narcissistic entitlement, psychotic transferences, threats of suicide and impulsivity can also be challenging in relation to the Mental Health Act (1992).

Treatment issues

There are several issues that impact on the treatment of a client with BPD and which are important for nurses to be aware of. These are discussed prior to the exploration of psychotherapeutic and psychopharmacological treatments.

Transference and counter-transference

The therapeutic alliance is the foundation of therapy, which is often difficult to establish and maintain, particularly in the face of disruptive pressures that arise in therapy with a client with BPD (Meissner, 1993). This alliance and transference and countertransference are called "the therapeutic tripod" by Meissner. In the transference, the client relives their relationship with their parents through the nurse and can be very perceptive about who is working with them. This survival skill was learnt through anticipating the needs of their caregivers to prevent victimisation (Van der Kolk et al., 1994). Often an equally strong counter-transference is evoked in the nurse because of the strong emotion and conflict in the transference, which can include helplessness, fury and despair. Nurses can feel a need to rescue or compensate (Van der Kolk et al., 1994). In order to remain therapeutic, it is essential for nurses to know themselves, have safe spaces to review these issues in supervision and ensure they get support from their clinical teams.

Safety

Van der Kolk et al. (1994) suggest that negotiating safety and forming safe attachments are a way in which a client with BPD is able to regulate their internal state. This is especially the case if people with BPD are fixated on the

emotional and cognitive level at which they were traumatised and continue to deal with difficulties using the resources at that point in their development . The authors recommend that basic trust and safety are negotiated prior to approaching trauma related material.

Hospitalisation

Gallop (1985) suggests that hospitalisation is an important aspect in the management of acute episodes for people with BPD. Budget and fiscal constraints mean that people with BPD are more commonly admitted for the relief of acute symptoms, usually a shift from chronic suicidality to acute suicidality, rather than for personality restructuring. Gallop reviews the two main clinical approaches for the hospitalised person with BPD. The adaptational approach focuses on preventing regression and encouraging people to take responsibility and has a short-stay emphasis, where staff offer supportive therapy, structure and limit set. In contrast, the long-stay approach allows for regression to take place in the presence of warm and empathic staff who facilitate the process of personality restructuring. The critics of this approach argue that it leads to the exacerbation of borderline symptoms. Gallop proposes an alternative model based on the work of Linehan (1993), but which adapts dialectic behavioural therapy for use in an in-patient setting in order to maximise the current short-stay emphasis and to use the skills of clinicians. Dialectic behavioural therapy will be discussed later in this article.

Dissociation

Research has found dissociation to have a high correlation both with the degree of borderline psychopathology and with the severity of childhood trauma (Van der Kolk et al., 1994). Dissociation is a way of coping with inescapably traumatic situations by allowing the person to detach from the reality of the situation. Often there is a loss of the memory and the relief of pain for the situation, the person can feel numb or spaced out. For some people this becomes a conditioned response to stress even if the situation is not inescapably stressful (Van der Kolk et al., 1994).

Splitting

A defence mechanism seen in clients with BPD is “splitting” (Harney, 1992) which can increase clinical risk if alternate strategies are recommended in the management of suicide risk. This risk can be reduced by ensuring clear communication and management plans across all services. Case management, where one person is responsible for the overall co-ordination of services and meetings with other care providers can also minimise splitting (Nehls & Diamond, 1993).

Psychotherapeutic interventions

A systems approach

Nehls and Diamond (1993) state that people with BPD have diverse treatment needs, so treatment should be based on comprehensive assessment and subsequent individualised treatment planning. This can be difficult for several reasons including: the number and intensity of crises that a person with BPD can have; the theoretical orientation of the clinician and interventions that are made hastily and based on negative reactions to a client or the diagnosis of BPD rather than careful assessment.

Nehls & Diamond propose a systems approach that includes: Individual counselling and psychotherapy; group therapy; medication evaluation and monitoring; drug/alcohol services; psychosocial rehabilitation and crisis intervention services. Planning should also include hospitalisation. Shea (1991) adds that several factors are intrinsic to any of the therapeutic approaches. These include careful attention to the client, skill to address countertransference, flexibility of therapy but also the need for limit setting with the therapist taking an active role.

Psychoanalytical

Shea (1991) suggests two types of psychoanalytic therapy can be helpful. Supportive psychoanalysis focuses on the improvement of adaptive functioning by strengthening defences and avoiding regression and transference by focusing on the present and keeping therapy highly structured. In expressive psychoanalysis, transference and regression are

desirable and provide a means for the therapist to gain insight. Behaviour is changed as dissociated aspects are identified and clarified as they appear.

Dialectical behavioural therapy

Linehan 's (1993) Dialectical Behavioural Therapy (DBT) emphasises that the person with BPD has inadequate affect regulation related to biological factors and a childhood environment that is characterised by an absence of emotional regulation. DBT focuses on identifying skill deficits in a person's life and then correcting them. The therapist teaches the client both self and relationship management skills as well as skills of mindfulness, interpersonal effectiveness, distress tolerance and emotional regulation. Therapy takes place individually and in groups and the relationship between therapist and client is paramount in treatment. In a one year trial of DBT, Linehan found that control group subjects remained in treatment longer, parasuicidal behaviour decreased as did the number of days of in-patient hospitalisation (Linehan, 1993).

Cognitive therapy

Cognitive therapy has been modified to treat clients with BPD (Beck, 1990) despite being thought of as most useful in the treatment of Axis I disorders (Shea, 1991). Arntz (1994), an advocate of cognitive therapy, argues that chronic traumatic abuse in childhood leads to fundamental beliefs that include: Others are dangerous and malignant, I am powerless and vulnerable and I am bad and unacceptable. The aim of cognitive therapy is to identify and change these beliefs, so affect and behaviour are normalised. Control over emotions and impulses are increased and identity is strengthened (Shea, 1991; Van der Kolk et al., 1994). Transference reactions provide rich material for uncovering dysfunctional thoughts and assumptions (Shea, 1991). Controlled studies have not been done as to the efficacy of this treatment approach with people with a borderline personality disorder (Shea, 1991).

Group therapy

The advantages of group therapy for the person with BPD include diluting transference and decreasing polarisation because of multiple feedback (Greene and Ugarizza, 1995). Group therapy can decrease demanding behaviour, egocentrism, social isolation and withdrawal and social deviance (Horowitz,

1987 cited in Greene and Ugarizza, 1995). Van der Kolk et al., (1994) state group therapy provides both words and actions for expressing emotional states that clients with BPD have difficulty with and can borrow from other group members.

Family therapy

Research has shown a strong link between BPD and pathological families (Clarkin et al., 1991 cited in Greene and Ugarizza, 1995). Family members learn therapeutic interactions so the identified client can begin to form an identity and both the client and family modify their behaviour (Clarkin et al., 1991 cited in Greene and Ugarizza, 1995).

Alternative therapies

Van der Kolk et al., (1994) advocate using psychodrama and drawing to develop language for effective communication as a precursor to effective psychotherapy. The authors' state that research has shown traumatised children have poor language skills for expressing their internal states. This can result in unmodulated actions, which are acted out in transferences and current relationships.

Psychopharmacology

Van der Kolk et al., (1994) propose that trauma affects a persons ability to self-regulate their emotions and self-soothe. Learning to tolerate affect is a way in which a traumatised person can take part in life. Mood stabilisers such as Lithium and Carbamazepine can help decrease affective lability and impulsive behaviour (Cocarro et al., 1991), whilst antipsychotic medication can help control transient psychotic states and antidepressants help with major depression (Shea & Kocsis, 1991 cited in Greene & Ugarizza, 1995). Linehan & Kehrer (1993) recommend being aware of contraindicated effects of medications, problems with compliance, drug abuse and suicide attempts. However, as long as careful monitoring is in place Linehan & Kehrer argue that pharmacotherapy can be a useful adjunct to psychotherapy.

Conclusion

This article has reviewed ways of viewing BPD. The medical model remains dominant in most psychiatric settings in New Zealand but other paradigms are gaining prominence as the limits of the medical model become more evident, particularly around the management of the client with BPD. The way in which BPD is defined remains contentious and many writers in the field suggest that it is more a response to trauma than core personality pathology. This has implications for how people with BPD are cared for in New Zealand's mental health system.

As nurses move into the role of case managers in the community, a systems approach incorporating thorough assessment and planning is a good beginning which includes assessing for previous trauma. There is also a need for multiple treatment modalities to include a variety of components such as assistance with daily living needs, pharmacotherapy, dialectical behaviour therapy, cognitive therapy and so forth. Nurses need to disengage themselves from the shadow of the medical model and begin to explore new ways of supporting clients with BPD in the community. In order for community mental health nurses to maintain therapeutic relationships with clients with BPD, they must be proactive and attain supervision, education and self-knowledge.

References

- American Psychiatric association. (1994). Diagnostic and Statistical Manual of Mental Disorders, (4th Ed.). Washington D.C: Author
- Arntz, A. (1994). Treatment of Borderline Personality Disorder: a challenge for cognitive-behavioural therapy. Behavioural Research Therapy, 32, 4, 419-430.
- Beck, A.T.& Freeman, A. (1990). Cognitive therapy of personality disorders. Guilford Press: New York.
- Brown, L.S. (1992). A feminist critique of the personality disorders. In L.S. Brown & M. Ballou (Eds), Personality and psychopathology, feminist reappraisals, (pp 206-228), New York: Guilford Press.
- Crowe, M. (1996). Cutting up: Signifying the unspeakable. Australian and New Zealand Journal of Mental Health Nursing, 5, 103-111.
- Gallop, R. (1985). The patient is splitting: everyone knows and nothing changes. Journal of Psychosocial Nursing, 23, 6-10.
- Gallop, R. (1992). Self destructive and impulsive behaviour in the patient with borderline personality disorder. Archives of Psychiatric Nursing, 6, 3, 178-182.
- Gallop, R. (1997). Caring about the client. In S. Tilley (Ed), The Mental Health Nurse, (pp28-42), Oxford: Blackwell Science.
- Greene, H& Ugarizza, D.N. (1995). The 'stably unstable' Borderline personality disorder: History, theory and nursing intervention. Journal of Psychosocial Nursing, 33, 12, 26-30.
- Gutheil, T.G. (1985). Medicolegal pitfalls in the treatment of borderline patients. American Journal of Psychiatry, 142, 1, 9-14.
- Harney, P. (1992). The role of incest in developmental theory and treatment of women diagnosed with borderline personality disorder. Women and Therapy, 12, ½, 39-57.
- Herman, J.(1994).Trauma and recovery. Harper Collins: London.
- Kaplan, H.I & Sadock, B.J. (1991). Synopsis of psychiatry, behavioural science, clinical psychiatry. Williams & Wilkins: Baltimore.

- Linehan, M. (1993). Skills training manual for treating borderline personality disorder. New York: Guilford Press.
- Linehan, M. & Kehrer, A. (1993). Borderline personality disorder. In D.H Barlow (Ed), Clinical handbook of psychological disorders (2nd ed.). New York: Guildford Press, 396-411.
- Mahler, M.S., Pine, F., & Bergman, A. (1975). The psychological birth of the human infant: Symbiosis and individuation. New York: Basic books.
- Meissner, W.W. (1993). Treatment of patients in the borderline spectrum: An overview. American journal of psychotherapy, 47, 2, 184-193.
- Nehls, N. & Diamond, R.J. (1993). Developing a systems approach to caring for persons with a borderline personality disorder. Community Mental Health Journal, 29, 2, 161-171.
- Shea, M.T. (1991). Standardised approaches to individual psychotherapy of patients with borderline personality disorder. Hospital and Community Psychiatry, 42, 1034-1037.
- Skodol, E. & Oldham, J.M. (1991). Assessment and diagnosis of borderline personality disorder. Hospital and community psychiatry, 42, 1021-1028.
- Stone, M.H. (1993). Paradoxes in the management of suicidality in Borderline Patients. American Journal of Psychotherapy, 47, 2, 255-271.
- Van der Kolk, B.A., Hostenler, A., Herron, N & Fislser, R.E. (1994). Trauma and the development of borderline personality disorder. Psychiatric Clinics of North America, 17, 4, 715-731.
- Widiger, T.A. & Weissman, M.M. (1991). Epidemiology of borderline personality disorder. Hospital and community psychiatry, 42, 1015-1020.