Nursing Management of Borderline Personality Disorders: Thriving on Chaos

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General principles of management of patients with personality disorders admitted in crises to the in-patient environment are discussed. The role of the acute ward in the overall plan of care, the relevant clinical thresholds to consider in deciding whether admission is appropriate and the main elements of the in-patient care plan are outlined. The management of patients with borderline personality disorder, who constitute the majority of such admissions, is discussed in detail. Less-common personality disorders affecting patients admitted to in-patient units are discussed in some detail. These disorders are rarely a direct cause of admission, but they are often associated with other Axis I disorders and can therefore be obstacles to successful treatment. A working knowledge of the clinical picture and underlying dynamics, and an awareness of counter transference feelings that these patients are likely to provoke can enhance therapeutic alliances and improve the chance of effective care plans.

INTRODUCTION

Paradigms regarding the management and treatment of clients with a diagnosis of a personality disorder have caused considerable controversy among psychiatrists, psychiatric nurse specialists, and mental health professionals. Debates, and articles indicate that there is a major split amongst professionals, with a strong lobby suggesting that people with personality disorders should, in the current state of knowledge, be considered either not treatable at all or, perhaps more appropriately, treatable only in specialized settings. This view is supported by the apparent lack of reliable and robust treatment data that could offer reasonable assurance of good clinical outcomes. The debate about dangerous and severe personality disorders and the possibility of such a diagnosis being open to possible compulsory detention has separated viewpoints even further.

Recent guidance published by the National Institute of Mental Health in England has helpfully raised many issues relating to this often-excluded group, which prevalence studies suggest constitutes 10–13% of the population (National Institute of Mental Health in England, 2014).
This report has suffered wide criticism, as it tends to play down the role of the acute in-patient setting in the lifetime experiences of people with personality disorders.

While this debate continues, most nurses and clinicians in adult psychiatry have to face the fact that, whether they like it or not, they may have to manage people with personality disorders in acute settings at some time, either because of a crises that leads to emergency psychiatric admissions, or because Axis II (DSM IV) personality disorders complicate other presentations, such as depression and schizophrenia, and require complex and professional treatment if the basic issues are to be appropriately tackled.

The aim of this paper is not to suggest that all personality disorders are treatable in the acute in-patient setting, but to look at the resources that are available in those environments that can respond to the extremes of personality difficulties, whether patients are admitted with this sole diagnosis in a state of crisis, or whether personality is an added dimension of another co-morbid psychiatric diagnosis.

My approach in this paper is to look at the possibility of acute clinical and nursing management strategies in certain types of personality disorder and, if favorable circumstances allow, to extend beyond this, incorporating a longer-term community outlook. This model of care has recently shown some promising results (Chiesa, 2002). Although I agree that acute in-patient units are mostly unsuitable for long-term work with people with personality disorders, I agree that ‘an admission, although often problematic, can be conceived as an opportunity’ (Hinshelwood, 1996). In all of these presentations, the question for clinical staff is whether the patient can embark on any meaningful change to their distorted behavioral and emotional patterns in an appropriate therapeutic environment. For this to be able to happen, staff will have to widen their knowledge and skills base and be supported and supervised by local specialist teams dedicated to the assessment, management and treatment of personality disorder. The different characteristics of personality configurations make it impossible to state, or describe any definitive formulaic approaches to problems, and therefore initially it may be discreet to visit the standard currently defined diagnostic categories and then, with the help of descriptive clinical pictures, try to ascertain whether the in-patient acute environment can contribute to the management of these disorders. It has been well acknowledged that a number of commentators are critical of these systemized descriptions of these entities, but accept that for the moment they are the best we have and, following the direction of the highest number of writers, I have relied on the DSM–IV classification (American Psychiatric Association, 1994) (figure 1). The descriptions and discussions describing the presentations of schizoid and ‘schizoid’ type personality disorders and their intervention are grouped together, as they tend to be treated in similar ways. I have also excluded reference to narcissistic personality disorders, as many researchers, commentators and refuted psychiatrists globally believe that it is a diagnosis of questionable validity and the likelihood of a patient with this personality dimension being admitted to hospital is exceedingly small.
Figure 1: DSM–IV classification of personality disorders

Cluster A (odd, eccentric types)

1. Paranoid personality disorder
2. Schizoid personality disorder
3. Schizotypal personality disorder

Cluster B (dramatic, emotional or erratic types)

• Borderline personality disorder
• Narcissistic personality disorder
• Antisocial personality disorder
• Hysterical and histrionic personality disorder

Cluster C (anxious and fearful types)

• Obsessive–compulsive personality disorder
• Avoidant personality disorder
• Dependent personality disorder

1. MANAGEMENT PRINCIPLES

The National Institute for Mental Health in England (NIMHE) has identified many of the guiding principles of effective therapy for people with personality disorders. Aspects of these can be taken into account when we envisage the role of nursing and the acute ward in the management of care. One of the controversial points in this area is the clinical thresholds that need to be set as indicators for in-patient admissions cited by Bateman & Tyrer, particularly taking into account the possible harmful effect on the patient or others of such an intervention (Figure 2). Translated to an in-patient service, the main elements of psychiatric interventions are listed in Figure 3.

Part of the perceived problem that is created by patients with an Axis II disorder is that they are, on the whole, very unpopular with clinical staff, and this therefore does not contribute to the creation of a positive therapeutic alliance. The switch that occurs from the role of victim to that of classic perpetrator provokes equally extreme responses from staff, from ‘kind defender’ to ‘Cruel attacker’ (Norton & Dolan, 1995).
Figure 2: Indicators for admission of patients with a personality disorder

- Crisis intervention, particularly to reduce risk of suicide or violence to others
- Co-morbid psychiatric disorder such as depression or a brief psychotic episode
- Chaotic behavior endangering the patient and the treatment alliance
- To stabilize existing medication regimens
- Review of the diagnosis and the treatment plan
- Full risk assessment
- Above all, the unit must have the capacity, in terms of skills, staffing and clinical pressures, to manage the admission

Not everybody can work or finds it fulfilling to work with patients with personality disorders. Duggan, 2002 has identified some of the key competencies of staff that can, and often does work with such patients. These include emotional resilience, clarity about their personal and interpersonal boundaries, and the ability to tolerate the intense emotional impact that these patients can have on them. Added to this is the need for effective and regular supervision, at both individual and team levels.

Figure 3: Management principles in the treatment of personality disorders.

Staff should devote effort to achieving adherence to the treatment, which should:

- be well structured
- have a clear focus
- have a theoretical basis that is coherent to both staff and patient
- be relatively long-term
- be well integrated with other services available to the patient, using a multidisciplinary approach as a main means of networking, communicating and reviewing plans between different elements of the service
- involve a clear treatment alliance between staff and patient
Figure 4: The main elements of psychiatric intervention in an acute in-patient setting

- Informality
- Careful assessments completed by experienced staff, focusing on the present crisis and need for containment
- Involvement of significant others, primary & secondary carers, relatives and other agencies in the assessment
- Early care plan with specified goals agreed and communicated to all staff and the patient, paying special attention to perceived or real inconsistencies. Anticipation of precursors to crises, especially impulsive discharge, self-harm, drug use, sexual promiscuity or aggression, and establishment of an agreed multidisciplinary response
- A focus on immediate needs, mostly of a skills based, practical nature
- Clear boundaries regarding tolerable behavior, including aggression, suicidal gestures, use of illicit substances or alcohol and presence on the units
- Effective use of psychotherapeutic and informal in-patient groups
- Treatment of psychiatric symptoms with medication when necessary
- Staff support groups and supervision looking at counter transference reactions, particularly of junior staff, who may become manipulated and over involved
- Early discharge arrangements when crisis has been overcome
- Readiness to discharge if goals are not met
- Referral to community or specialist services on discharge, with close and careful handovers through multidisciplinary team involvement
- Short duration of admissions
- Consideration of co-morbidity of a personality disorder if treatment for an Axis I disorder does not meet with the predictable response

2.

BORDERLINE PERSONALITY DISORDER

The patients that present displaying psychopathology of this diagnosis consist predominantly of female patients, and are more likely to be admitted in a crisis to an in-patient environment. The admission usually involves presentations of suicidal or self-harming intent. Although the diagnosis of borderline personality disorder is controversial, and is still being argued about, the combination of features listed below is not only clinically recognizable but makes these patients most likely to present after hours to a busy, and overwhelmed, junior doctor on-call.
Figure 5: Features of Borderline Personality Disorder.

- Impulsive and sometimes manipulative self-injurious, self-destructive behavior;
- Pathological attachments tinged with fear and dread of abandonment,
- Unstable erratic self-image,
- Labile mood,
- Transient circumscribed psychotic-like or magical thinking,
- Overwhelming angry demands and feelings of entitlement.

The fears created by what might happen if these patients are not contained inevitably leads to an admission. The histories gained from these patients typically reveal parental rejection and abandonment as well as sexual abuse at early stages of their development; accompanying recent incidents of assault or neglect are more often than not the causal triggering factors. Those supporting a biogenetic model have also observed a preponderance of attention-deficit disorders, learning disabilities and conduct disorders contained in the histories of these patients.

Patients that are admitted to inpatient units with borderline personality disorder can provoke the most extreme counter transference feelings in clinical and allied staff members, who often report that they feel abused and deceived. The tendency of these patients to either deify or demonize their care providers, dependent on whether their perceived urgent and immediate needs are gratified or not, places staff in very difficult and sometimes unpleasant dilemmas. In the same vein, these patients may present as being acutely depressed and sad one minute, and the next may be playing games and laughing with their fellow patients as if nothing has happened. The management difficulties posed by these patients when they are suicidal are particularly troublesome, and may include accusations towards staff that they do not care enough, are insensitive towards them, or have lost hope in them, or even, secretly wish them to die. In the current healthcare culture of risk management and serious-incident investigations, this may be extremely difficult to bear. It can cause staff to feel that they carry more of the burden of responsibility for keeping these suicidal patients alive than do the patients themselves, a condition which has been well described as coercive bondage (Hendin, 1981). The catch-22 in this scenario is that analysis of completed suicides by patients with borderline personality disorder has shown that perceived rejection by caregivers has often been the precipitating cause (Kullgren, 1985).

Although disturbing these negative features should be put into context. Formal empirical studies of the natural course of this illness are rare, but analyses of the data collected from patients that are, or have been in contact with psychiatric services report generally good outcomes over prolonged periods of observation. This is especially true if the patients’ impulsive behavior at the peak of their presentation does not prematurely lead to a tragic end, which, considering the frequency of suicidal threat is not that common (Stone, 1990).

As with all other groups of personality disorders, there are no quick and easy answers with patients in the group of borderline personality disorders. Although some researchers have reported that there are considerable improvements demonstrated in specialized units run on
psychodynamic theories (Bateman & Fonagy, 1999). Clinicians have also noted that working from cognitive–behavioral or dialectical behavioral lines can produce dramatic initial effects (Linehan et al., 1991; Gunderson, 2001), this being said these interventions are not easily available in all districts, and not all clinical staff is well versed in their use.

3. PARANOID PERSONALITY DISORDER

The key features that present in paranoid personality disorder are ego-synchronic, so it is not uncommon for a patient’s relatives, friends or even work colleagues to lose patience with constant suspicious and accusatory behaviors. Their increased awareness of ‘what may lie beneath the surface’ can have the effect of making people with this disorder intolerable to those around them, this therefore requires considerable expenditure of energy and time on their behalf when they become patients (Gabbard, 2000).

A diagnosis of paranoid personality disorder implies that a patients’ thinking is not strictly delusional, but rather their cognitive thinking style and cognitive functioning involves a distortion of reality that is very often determined by their past history. This rigid outlook held onto by the patient is translated into their pattern of relationships, ostensibly characterized by a constant search to confirm the negative suspicions about those that are around them.

Although there is an adoption of the ‘victim role’, there is also conversely, a great need to control their alleged persecutors, this is often reflected by unacknowledged low self-esteem, and often compensated for by demonstrations of grandiosity. This makes the patient extremely vulnerable to the very real fear of being humiliated by any person that may be in a position of authority. This is one of the major obstacles to any chance of building a clinically therapeutic relationship. Verbal attacks and accusatory behavior towards staff often provokes defensive explanations, which are then received, and perceived with even more suspicion, therefore creating a paranoia cycle of response.

Research suggests that the large majority of people with paranoid personalities are not known to any psychiatric services, and those who are in contact with service providers initially have been referred to psychiatric services and out-patient clinics by their families or employer. However, there is the rare occurrence that they are admitted to hospital as a result for example of an aggressive physical attack on a close relative neighbor, or a colleague at work, the attack incited by their heightened suspicions. Initial assessment following from this event is likely to involve thoughts around a differential diagnosis of paranoid schizophrenia, it will become very quickly apparent though that this is not correct, and once this alternative has been discarded, the challenge for psychiatry and for nursing staff is to investigate whether the admission, even if brief, can be used as a positive evidential proposal for further psychiatric or psychological interventions. Anecdotally it is thought that more often than not, admissions of this brief and constrictive type end up confirming the patient’s paranoia and suspicions about psychiatric services, thus resulting in a lost opportunity. The response of the patient will greatly depend on the staff’s ability to manage paranoid projections without counterattacking or responding in a defensive manner. Staff on the units will need to be resolute in their ability to also withstand the onslaught of accusations and demeaning remarks that will at some stage of the admission become apparent. Any successes in this regard have the possible consequences of establishing a level of contact with the patient that can be utilized either straight away for positive reinforcement or alternatively charted, and used at some time in the future. One useful
technique in the handling of this presentation is to acknowledge the efforts that patients have to expend to keep those around them at a safe emotional distance. This approach may have the effect of eventually empowering the patients with the permission, or ability to acknowledge their own fears and weaknesses; this is something that patients with this type of personality will desperately defend themselves against. This therapeutic shift, which in most cases will happen in the patients’ own time and in a clinically enabling therapeutic framework, will permit patients to contemplate an alternative view to their previously rigid and stereotypical perception of the world around them. The propensity towards violent conflict as previously mentioned, is one of the major factors that is likely to bring paranoid individuals into the hospital setting, this risk will remain present during the admission and require clear, and noted strategies to prevent it (Figure 6).

Figure 6: Violence-prevention strategies (adapted from Gabbard, 2000)

*Help patients to save face:* Staff must be particularly aware of patients’ low self-esteem and of their need to keep this hidden from themselves as well as from the outside world

*Avoid arousing further suspicion:* Staff should explain each and every movement that they make and should avoid ingratiating friendliness

*Be prepared to be openly firm when necessary:* This may involve straight talking; when decisions have to be made that could be perceived as persecutory, staff should clearly explain how they have come about and in whose interests they would be

*Help patients to feel that they are in control:* Staff must openly acknowledge why patients have construed the world around them as they have and must respect their need for autonomy

*Encourage verbalization rather than physical acting out:* Staff should sense and support patients’ experience of anger and, together with them, consider the consequences of violence

*Give plenty of breathing space:* Avoid close seating arrangements and physical contact

*Tune in to own counter-transference denial of violence:* Remember that women are as likely as men to assault staff (Tardiff et al, 1997). Be aware of your own aggressive and provocative feelings

4. SCHIZOID AND SCHIZOTYPAL PERSONALITY DISORDERS

Although there is still much debate regarding the inclusion of diagnoses of this type among the Axis II group of disorders, the very persistence of social detachment and blunting of affect, ‘magical' thinking not adding up to verification of delusional processes, and unconventional behavior have placed this diagnostic schema within the disorders of personality rather than the psychotic-spectrum of Axis I disorders where the indices would be according to common
diagnostic criteria.

By the very nature of the diagnosis, this type of patient rarely comes to the attention of general psychiatrists by referral, and even more rarely is the referral to in-patient units, unless the level of social isolation, self-neglect and eccentric, bizarre behavior lead to a referral being made under the mistaken diagnosis of schizophrenia. Occasionally, relatives access a family Doctor, Community Nurse or Psychiatrist, concerned that the person is not ‘engaging enough with life’ and has withdrawn excessively. Some patients share the notion that they are mere shells of disassociated personality, with no life or feelings, not being able to identify who or what they are and, as a result of this are incapable of establishing or sustaining meaningful emotional relationships. Emotional proximity carries with it the perceived threat of being engulfed or even taken over by other personalities, and therefore extinguished or detached, and yet there is a need to remain attached in order to survive: what Guntrip (1968) called the ‘schizoid compromise’.

Paradoxically, therefore, not being connected permits people with these schizoid type personalities to believe that they are defending their ‘true self’ against being overpowered by others and therefore transformed through these interactions into a ‘false self’ (Winnicott, 1965) Patients that are resident at the in-patient unit with schizoid personality features present various management problems (Figure 7). On admission, they become demonstrate behaviors characteristic of patients with the withdrawn symptoms of a schizophrenic and seek refuge in their bedrooms or a quiet corner of the unit. The patient initially will avoid all interactions with staff or other patients, at least until they are able to feel relatively secure. Any group activities are experienced as threats to the self, and attempts at forcing participation will be severely resisted. With encouragement the patient may gradually become more amenable, this can provide for the patient perhaps for the first time in their lives, an opportunity to explore relations and emotions in a relatively safe context. The challenge then is for staff not to collude with their detachment and distancing techniques, not to allow them become just an inanimate part of the unit. Staff must be aware that, although silence can be a form of stiff resistance, it is also a powerful technique for communication and an attempt at relating, but sharing this relationship in a non-constrictive way demands extraordinary determination and flexibility. In a sense, it is a way of accepting the psychoanalytic ‘true self’ that the patient is so desperately trying to protect and to defend. Those members of staff trying to relate on the same level to such patients will have to examine carefully their own reactions, (perhaps with a clinical supervisor)and perceive what sort of feelings are being engendered in them, as these feelings may give an indication of what the patient is going through or is attempting to communicate. The assignment for clinical staff then is to explore how these feelings can be shared with the patient in a way that can be positively accepted and that can give the patient an opportunity to learn from them in a non restrictive and non-committal way.

The possibility that a therapeutic relationship may be formed and the chance that the patient may be beginning to establish a modicum of relatedness will depend acutely on the degree and severity of withdrawal. Staff may need to be aware and prepared to accept the unexplainable reactions of some patients and to be able and willing to function as a supportive alter ego in practical areas such as personal physical care, reality testing and reality checking and basic interpersonal and social skills. As they become more comfortable, these patients will be more able to accept group activities, which are an ideal setting in where the taught socialization techniques and ability to relate to peers can be explored, and expanded upon.
Nurses and therapists that work in these settings will have to be aware that there is the possibility that other staff may gang up on individual patients in order to gain information from them or conversely, simply ignore them and treat them as if they were not there. The use of antipsychotic medication in schizotypal personality disorder has also been discussed as an aid to engagement and reduction of withdrawal behavior (Davison, 2002).

Figure 7: Interactive issues in the management of patients with schizoid personality disorders

- Accept silence as a powerful form of communication
- Be prepared to feel rejected and distanced
- Be careful of persistent probing
- Accept the patient’s rhythm and pace of change
- Validation by other patients often carries more weight than validation by staff

8. ANTI-SOCIAL PERSONALITY DISORDER There is recognition amongst clinicians that the most challenging of patients in the personality index are those with the diagnosis of antisocial personality disorder many patients who are diagnosed in this schema are considered untreatable, therefore requiring corrective rather than therapeutic interventions. The patients diagnosed in this way and with this disorder are sometimes incorrectly referred to as psychopaths, sociopaths or character disordered, this descriptive terminology has reduced in use because of its derogatory connotations.

There remains much diagnostic controversy about the terms psychopath and sociopath. However, Gabbard (2000) suggests that the antisocial personality disorder lies on a continuum along with narcissistic personality disorder, and that therefore the ability to treat will depend largely on a definite understanding of where each patient is on this continuum.

According to the National Institute for Mental Health in England (2001) this condition indicates the epidemiology of 2–3% lifetime prevalence. The diagnostics are indicated highly in impoverished areas, and the condition has been strongly associated with criminal behavior and drug and alcohol misuse. There is a strong male index, between 4:1 and 8:1, but there is a tendency from psychiatrists to under diagnose this disorder in women because of the effect of stereotypes. Obstetric complications and prenatal brain injury, lowered autonomic nervous system responses, maternal rejection, physical abuse, negative family environments, and conduct and attention-deficit hyperactivity disorders have all been implicated in the etiology, but not in a definitive sense.

From a psychodynamic perspective, the absence of superego development and of any attempt at moral justification of aggressive antisocial behavior or lying in order to avoid responsibility makes these patients poor candidates to respond to any therapeutic approaches, let alone to engender any empathic responses from staff. There are, however, gradations in this area, and some patients are able to experience a degree of guilt or concern, even in the light of repeated
antisocial acts, which may make them amenable to interventions. These interventions are most effective if carried out in residential or in-patient psychotherapy units that work within clearly defined boundaries. Any admission to a general psychiatric unit is inadvisable, due to the likelihood that the patients will disrupt the general milieu of the unit and the treatment of others by breaking conventions and undermining unit therapeutic activities and the ability of staff. Some patients can charm staff into thinking that they are benefiting from their care, whereas they are going through the motions without any real change; some patients convince staff that they are ‘victims of circumstances’ or only ‘bad’ when they use drugs or alcohol. These patients may take advantage of the compassion of staff, or the need of staff to be helpful, encouraging them to play down the patient’s behavior, even in the light of previous negative experiences. Needless to say, these patients can, and will arouse extreme negative responses in staff. To some degree this depends on the setting: counter transference in a hospital is very different from that in a correctional institution. Antisocial personalities tend to obtain very polarized feelings from staff: from the desire to punish and to seek reprisal, to the illusion that staff can defeat evil by their kindness; from outrage to admiration, hopelessness to fear added to this are the dangers of being deceived, as these patients regularly distort facts and lie, thereby disabling any semblance of a trusting therapeutic alliance.

Patients that are admitted in crisis should be assessed rapidly and the decision taken either not to treat but to take prophylactic risk-management actions or, if there is scope for intervention, to refer to the relevant service, and access them as soon as possible. While this is happening it is extremely important that strict boundaries and conditions are set with the patient regarding aggressive behavior, sexual acting out, or inappropriate sexual advances, theft and drug or alcohol consumption, with consequences if these are transgressed. The staff groups’ feelings of disbelief, rationalization and collusion must be carefully monitored.

Fear of assault by the patient may lead to the loosening of agreed behavioral boundaries due to the very real fear of provoking a reaction. Any breaking of set agreements and rules by the patient needs to be confronted immediately by the staff group, this is very important so that patients are aware of the consequences of their actions, and they should be encouraged to think and talk with a staff member before taking impulsive action. Unfortunately, this is not always feasible.

Gabbard & Coyne (1987) have produced a list of predictors (Figure 8) that can be used by in-patient units to assess potential for treatment, and the authors advise that staff should not to be led by ‘gut-feeling responses’.
Figure 8: Predictors of response to therapeutic approach in antisocial personality disorder.

Predictors of positive response

- Presence of anxiety
- Axis I diagnosis of depression
- Axis I diagnosis of psychosis other than depression or organic condition

Predictors of negative response

- History of arrest for a felony
- History of repeated lying, use of aliases, conning
- Unresolved legal situation on admission
- History of conviction for a felony
- Hospitalization as an alternative to imprisonment
- History of violence to others
- Diagnosis on Axis I of organic brain impairment

In summary, although the anti social personality disorder is rarely diagnosed there are particular ways that nurses will treat the diagnosis, and advice for dealing with antisocial personality disorder is summarized in Figure 9.

Figure 9: Dealing with patients with antisocial personality disorder (after Lion, 1999)

- Remain skeptical - particularly during assessments
- Do not deny or normalize dangerousness: a charismatic patient can lure staff into a forgiving or permissive response to unacceptable behavior
- Be aware of polarities in feeling: a patient’s assertiveness or even violence can arouse secret awe and admiration one moment, but disgust and punishment the next
- Be aware of the risk of sexual manipulation by patients
- Ensure that less experienced staff are supervised by a more experienced clinician

9. HISTERIC AL AND HISTRONIC PERSONALITY DISORDERS

Hysterical and histrionic conditions are not properly distinguished in DSM–IV. Hysterical conversion disorder is considered under conversion or somatoform disorder and is not related to hysterical personality disorder. Gabbard (2000) describes both hysterical personality disorder and histrionic personality disorder. He attributes to them shared behavioral characteristics such as a tendency to labile and shallow emotions, attention-seeking behavior, disturbed sexual
functioning, dependency and helplessness, and self dramatization. However, he differentiates hysterical personality as being healthier, whereas histrionic personality is more florid in every way, less subtle and more impulsive, functioning at a much more primitive level. This differentiation is often reflected in individuals’ respective success or failure to maintain relationships and work commitments, and in differences of degree of transference wishes. Although they are traditionally perceived as female disorders, hysterical and histrionic personality disorders have also been extensively documented in men. These have fallen into two broad subtypes: the hyper masculine Don Juan type, who is unable to commit himself to any relationship, and the more passive effeminate man, homosexual or heterosexual. In both genders the cognitive style is extremely impressionistic, with an inability to elaborate on any detail about the people or world around them, this may indicate a defensive emotional detachment (la belle indifference), although paradoxically, they may present with shallow emotionality. It has been found that women with histrionic personality disorder tend to have a history of maternal rejections this has the effect of drawing them to their fathers for their dependency needs. They become ‘daddy’s little girl’ and can repress their own sexual maturation and identity.

Women with hysterical personality disorder have usually had more satisfying early relationships with their mothers, but develop intense feelings of rivalry and will then compete for their fathers’ attention. In these relationships there are more likely to be episodes of actual incest. In adulthood they appear to be unaware of their attempts at seduction. As a result their own sexuality and there experience of intimacy is disturbed and unsatisfactory, as is their choice of sexual partners. It is usually a relationship crisis, leading to dramatic acts of impulsive self-harm, that results in admission to an acute hospital setting by way of the emergency department.

The presentation is similar for men. With men who have histrionic personalities, maternal (and paternal) unavailability may lead them to either emulate their mothers, adopting a very passive and effeminate role, or their fathers, mimicking hyper masculine cultural stereotypes of masculinity. In those with hysterical personalities, feelings of sexual inadequacy keep men attached to their mothers, again either adopting effeminate or celibate lifestyles, or causing them to overcompensate by shallow efforts at becoming tough ‘real men’. Both men and women that are diagnosed with these disorders pose difficulties in in-patient settings, as they often engage in rivalry with other patients and erotic transferences to staff. They usually perceive themselves as special, tend to take over groups, where they need to be at the centre of all discussions, and take on other people’s problems as part of their own, in a self-referential manner. If frustrated in their attempts, they are likely to become increasingly dramatic, and sometimes become involved in risk-taking behaviors in order to attract attention. This often provokes negative counter transference feelings in staff, who then try to ignore their demands, which has the effect of reinforcing the cycle. Although long-term work with these patients is the province of the out-patient clinic or psychotherapy department, two principles of patient management can be applied in the in-patient unit that might help patients succeed with more long-term work. Firstly, the initial assessment should be used as an opportunity to challenge the patient’s cognitive functioning style. However, this assumes that doctors and nurses instinctively know what is happening with these patients. History-taking (which can be a frustrating experience) is therefore extremely important, as it allows patients to describe, perhaps for the first time, their internal world, feelings and expectations. Second, erotic transference must be effectively managed. Erotic feelings towards staff can sometimes be very insistent and pervasive, and in an in-patient unit many nursing staff can be particularly vulnerable to overt or
covert advances. The management of transference involves a close examination of countertransference feelings. There are large hurdles to overcome if this is to be dealt with appropriately, as there seems to be no tradition in the UK for the open discussion of sexualized feelings, which are often ignored or denied in patients and staff. Nurses in particular have no statutory vehicle for expressing their concern and no peer based support system to rely on, any suggestions around the breaking of boundaries is immediately responded to in a punitive manner with little or no understanding of the impressionable effect of the patients with this diagnosis. It has been noted that staff can be so frightened of these consequences that they respond to patients’ advances with aggression or aloofness, which the patients read as evidence that sexual desires are dangerous or dirty. Another common response by staff is to tell the patient that their feelings are not real, when to the patient they are extraordinarily real. A more appropriate response is to communicate to the patient that sexual or loving feelings do occur but cannot be reciprocated. This acknowledges the reality of the feelings, but places them within a therapeutic process that can help staff to understand some of the patient’s inner thoughts and feelings, even if at times it is embarrassing or painful for the patient not to have their desires fulfilled.

10. OBSESSIVE COMPULSIVE PERSONALITY DISORDER In opposition to obsessive–compulsive disorder, this personality trait is ego-syntonic, and therefore does not cause distress to patients themselves, but is more likely to affect those with whom they live or work. In many cases, the symptoms are adaptive and can be an aid to successful careers. Excessive attention to detail, preoccupation with morality, values, order, rules and regulations, a tendency to perfectionism that can interfere with task completion, extreme devotion to work at the expense of other pursuits and relationships, as well as greediness are some of the most common features. The cognitive style of people with obsessive–compulsive personality disorder features rigid control over their emotions and an excessive reliance on logical, narrow-minded thinking.

People with the disorder are not usually referred to psychiatric services and are unlikely to end up in in-patient facilities, unless their defense systems decompensate with marked symptoms of anxiety, depression or self-neglect, usually around middle age. A feature of their presentations is the need to become perfect patients, attempting to control their anger, sadness or despair. This sometimes takes the form of rambling, circumstantial conversations that stray from the matter in hand and provoke staff to want to disengage or to prompt patients into action.

If an individual with the disorder is admitted to the inpatient unit staff should focus on the patient’s feelings rather than facts or words. Groups can be very effective in challenging a patient’s attempts to hide behind a smokescreen.

Initially, however, it might be necessary to respect the patient’s defenses. Counter transference feelings can be challenged and dismantled when the patient feels safe enough to disclose the profound feelings of insecurity and lowered self-esteem that are the root of this personality configuration.

11. AVOIDANT PERSONALITY DISORDER

Although this diagnosis has been linked by some researchers with the diagnosis of schizoid personality disorder, avoidant personality disorder differs in that those affected show a need for extremely close relationships, hampered by powerful fears of rejection and failure. They have an
intense dread of criticism and dismissal in both public and private encounters, and evidence suggests that there may be strong overlap with social anxiety and social phobias.

It is unlikely that such patients will be admitted to hospital unless they present with another, concomitant Axis I diagnosis. At the heart of these presentations is shame and self-exposure of internally perceived inadequacies. Dynamic and cognitive–behavioral approaches are the treatment of choice in out-patient environments, but the following clinical strategies are useful for patients admitted to hospital:

**Figure 10: Aims of consistent staff response to patients’ behavior.**

- offer an empathic response to embarrassment, coupled with encouragement to face the perceived feared situation;
- consider prescription of a selective serotonin reuptake inhibitor (SSRI) such as Seroxat™
- Consider the use of psycho-educational approaches to combat manifestations of anxiety.

**12. DEPENDENT PERSONALITY DISORDER**

Dependent personality disorder also regularly presents as a co-morbid condition with another Axis I disorder such as depression, alcohol dependence, any of the anxiety neuroses, or eating disorders, and rarely hypomanic symptoms. Intense submissiveness and attachment, linked with difficulties in decision-making ability and a tendency to easily relinquish responsibility to others, make it an important personality trait that affects the management of the Axis I disorder. Of note here is that the person identified as the primary caregiver can experience these demands as hostile and aggressive. Patients with the disorder are likely to become attached to staff on the unit or in the out-patient department, and they fear disastrous consequences if they are discharged from hospital or community care. Improvement is therefore seen as a potential threat.

Bearing this in mind, clinical strategies should focus on the patients’ responsibilities and independence. Clinical staff must feel comfortable in frustrating patients’ dependency needs, making them take decisions and promoting independent thinking and action. Time-limitations might help them to accept the fact that any symbiotic relationship will have to end. Staff must be attuned to counter transference feelings of contempt and the urge to bask in idealized roles attributed to them by patients.

**13. THE ROLE OF THE ACUTE INPATIENT SETTING**

Nursing journals have reported clinical results and qualitative experience that indicates that there is an enhanced role for the in-patient unit where patients are often taken in an emergency, especially if a graded and well-informed response can be agreed between the in-patient staff and patient. This approach requires excellence in team functioning and solidarity and clarity of purpose, as without these, team differences, and difficulties are very likely to be exposed by the
Effective leadership is also a requirement, and in particular a good understanding of purpose between the senior nurse, the nursing team, and the psychiatrist or medical staff (Piccinino, 1990). The aim therefore is to restore, or instill a sense of responsibility and rely on the patients’ previously good internal resources (Webster, 1991). These admissions should not be prolonged (Nehls, 1994) and the aim should be to deal with the emergent problems that have precipitated the crisis, and the subsequent admission.

Patterns of impulsive responses and wild fluctuations in attitudes and attachments to and from staff if witnessed should be discussed, and once the emotional crisis has subsided can be worked through in focused individual and group therapeutic interventions, which should have an emphasis on individual problem-solving skills. A major source of argument in both nursing and medical fraternities is the nature of response by clinical teams to a patient’s suicidal and self-harming behavior. Clear understanding of the meaning of that behavior and the aims of the staff’s response can help patients in a number of ways, for example by enabling them to (See Fig 11);

Figure 11: Aims of consistent staff response to patients’ behavior.

- To improve interpersonal skills during conflict
- To increase skills to regulate internal, unwanted emotions
- To develop the skills to tolerate emotional distress until change occurs
- To learn self-management (Gallop, 1992).

A difficult balance needs to be attained (primarily by observation) that will both ensure the patients’ safety whilst in the inpatient units care and avoid any collusion with helplessness and abdication of responsibility for the patient's own behavior (Sederer & Thornbeck, 1986). This group of patients are likely to try to cause major rifts in the team, they will try this by splitting it into two easily identifiable, warring factions, those who believe the patient to be manipulative and therefore in need of firm, controlling interventions, and secondly those who become overprotective of the patient, and tolerant beyond reasonable limits (Kaplan, 1986; O’Brien, 1998). The importance of staff discussions, availability of opportunities for supervision, and support groups in these circumstances cannot be overstressed. The clinical staff will have to be prepared for recidivism, and regular readmissions, it is helpful to keep a historical perspective, looking at changes no matter how small, over time, as this can give hope when the staff group feel despondent about any possibility of eventual change when all they see is repeated similar presentations.

14. DISCHARGE PLANNING

Throughout the previous text the discussion has been regarding the admission of the patients with challenges in their personality, this being said, it is vitally important not to lose sight of the
fact that, on discharge, these patients are likely also to become a concern for community clinicians, and therefore effective communication and sharing of ideas should be established between both the in-patient and community teams which should include sharing of leadership, and collaboration of provision.

In all likelihood the patients’ family members are also going to be enmeshed and entangled in the presentation and management of the patient, and sometimes they will contribute either unwittingly, or by clever manipulation by the patient to the splitting or undermining of coherent staff approaches. In both these scenarios, a multidisciplinary meeting, (which includes the patient, their family or primary caregivers, and both sets of clinical teams) where clear boundaries, expectations and responsibilities, as well as contingency planning, are discussed, can become a very useful tool.

As noted above, a major hurdle that has to be overcome in the management of these patients is managing the feelings of hopelessness that they provoke with repeated acting out behaviors, and incessant demands, with the continuous and deliberate crossing of boundaries and weak therapeutic alliances. This leads many patients on a journey to sabotage many well-prepared care plans, destroy any therapeutic alliances that have been developed, and to present only in states of extreme and major upheaval. In this situation, the in-patient unit can represent the only constant, a safe place that has the ability to contain and hold a person, even if this creates an ambiguous and sometimes intolerable attachment. This approach contrasts with the experience of most people with borderline personality disorder, who have had tenuous parental relationships that often end in their being abandoned to their own devices. It is apparent that they are in fact emotionally 'soothed' and supported by the notion that the safety net of the unit is available. Slowly, and over an extended period of time, many patients are able to process and appreciate this approach and to some extent take over the soothing role without their being precipitated into a crisis.

Another point to bear in mind is that patients with borderline personality disorder form a very diverse group, and that prescribed, structured and inflexible responses will not always be relevant or appropriate. Sometimes, patients just need to be heard, at other times supported. On occasions where risk-taking behavior is predominant, the set boundaries need to be firmly clarified and adhered to (Rouse, 1994). Staff will have to learn to discern when their patients are ready to benefit from some degree of confrontational and interpretive techniques, but before these techniques can be attempted, staff need to be comfortable with that specific type of approach, and patients need to feel that their internal feelings are empathically validated particularly if recent occurrences have opened up old wounds relating to early childhood traumas.

15. MANAGEMENT PRINCIPLES Figure 5 (below) summarizes several principles of the recommended techniques suggested by Gabbard (2000) that broadly apply to most patients with a diagnosis of borderline personality disorder. These principles are expanded on in Figure 6.
Figure 12: Principles of management of patients with borderline personality disorder in in-patient units

- Maintain flexibility
- Establish conditions to make the patient safe
- Tolerate intense anger, aggression and hate
- Promote reflection
- Set necessary limits
- Establish and maintain the therapeutic alliance
- Avoid splitting between psychotherapy and pharmacotherapy (see fig 6)
- Avoid or understand splitting between different members of staff, either in hospital or in the community
- Monitor counter transference feelings

The difficulties that patients with borderline personality disorder pose for staff in in-patient environments have already been indicated in the preceding text. A not uncommon scenario is that due to mitigating circumstances patients perceive themselves to be ‘special’ and different from others, therefore demanding extra attention. At other times they may form a clique with other like-minded individuals, or other patients with the same diagnosis, causing many challenging issues such as the purposeful disruption of the therapeutic milieu by sabotaging collaborative activities, undermining staff or disparaging their work in the unit. Others simply display passive resistance and go into overdramatic labile moods. Overall, the treatment plan aims to avoid regression and support the contention that patients can eventually restore their adaptive functions and control chaotic, or self-destructive urges. Pharmacological interventions are used only to help people take back control over their feelings, or for emergent physical symptoms of illness. The structure of the inpatient unit is integral to the patient’s rediscovery of appropriate adaptation in that the day implies the rediscovery of order, and a predictable pattern of interactive opportunities with individual staff and groups.

The focus is on the understanding of the precipitants of the crisis, the pattern of responses and how these link up with previous traumatic experiences. When the furore has reduced, patients may be able to look at alternative ways of responding, accept the consequences of their actions and be able to validate remaining ego strengths and abilities. When setting limits, staff must be able to say ‘no’ without malice, explaining that this is in the interests of the patient and not, as patients often construe it, a sadistic means of control. If there are attempts at self-harm behaviors such as cutting, or burning, staff may need to convey calmly that, although patients are responsible for their behavior, the staff will be there to do reparative minor surgery if necessary.
Figure 13: Principles of management – an elaboration

**Maintain flexibility:** Take into account the patient’s ego strength, psychological mindedness, level of intellect and emotional state when deciding whether to use interpretive or supportive techniques. Be prepared to make mistakes and to use a trial-and-error approach. Staff should be aware of their potential lack of responsiveness as a defense against the extreme feelings that these patients engender. Patients are likely to respond very negatively to stereotypical or rigid stances, and staff needs to be spontaneous as far as possible, yet keep professional boundaries.

**Establish conditions that keep the patient safe:** Set boundaries regarding the need for hospitalization, suicidal behavior, use of drugs and alcohol, and inappropriate crossing of professional boundaries

**Tolerate intense aggression and hate:** Remember that most patients are trying to re-establish their relationship with the rejecting parent by creating a sadomasochistic attachment to staff. Attempts at avoiding such projections, either by defensive countermeasures, trying to prove that the staff is in fact good, or by angry retorts and rejections is likely to lead to disengagement.

**Promote reflection:** "What triggered that extreme reaction?" "How do you think I felt when you attacked me in that way?" "What do you think are the consequences of cutting your wrists?"

**Set necessary limits:** These need to be clarified if behaviors threaten the safety of the patient, family, staff or the therapeutic relationship.

**Establish and maintain the therapeutic alliance:** Regularly revisit the aims and goals of the therapeutic contract, especially when either the patient or staff has lost their way.

**Avoid splitting between psychotherapy and pharmacotherapy:** Patients’ responses to prescribed medication must form part of the therapeutic interactions and be discussed openly if medication is resisted, sabotaged or abused. Patients may need reminding that the aims of medication are modest: to alleviate the most distressing symptoms and allow time and opportunity to reflect and share feelings.

**Avoid or understand splitting between members of staff, either in hospital or in the community:** Recognize that patients may display completely different attitudes, both loving and attacking, within short periods, which can be quite perplexing to staff. Patients are projecting these aspects of themselves onto others, as a way of trying to control these fragmented parts of them self.

**Monitor counter transference feelings:** Enable staff to share embarrassing or difficult feelings prompted by their involvement with these patients
REFERENCES


Policy Implementation Guidance for the Development of Services for People with Personality


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