FOR PROFESSIONALS IN INPATIENT SETTINGS

Safe Haven

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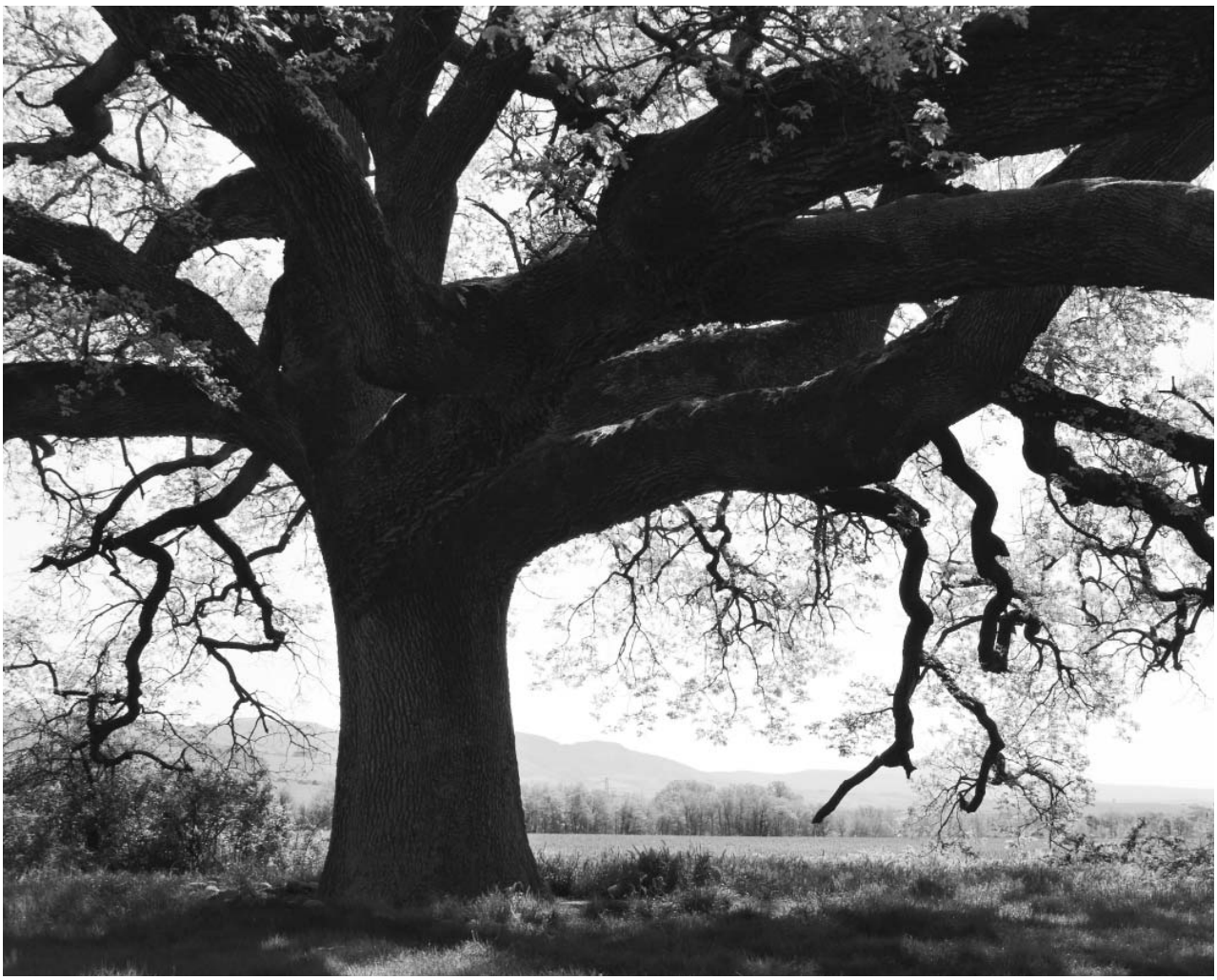

Skills to Calm and De-escalate Aggressive and Mentally Ill Individuals: 2nd Edition

A Comprehensive Guidebook for

Personnel Working in Hospital

and Residential Settings

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CHAPTER 11

Borderline Personality Disorder: Treatment in Short-term Psychiatric Facilities and Inpatient Crisis Units

Borderline personality disorder, like any pathological character trait, is a spectrum disorder, an accentuation of qualities common to all humanity. Any of us can be swept by feelings that seem beyond our control. Any of us can act on feelings that result in our making decisions that are not in our best interest, that may even be damaging to ourselves and others. Sometimes we are impulsive, and sometimes we get angry, even enraged. This alone is not the definition of borderline personality disorder.

The particular dilemma of borderline individuals is that they live in an existential universe: whatever they feel right now is their only reality. What for us are remarkable episodes in a usually calm and focused life are everyday occurrences for the person with borderline personality. Those on the mild end of the spectrum will be quite emotional, overreacting to events that others could take in stride. For those whose disorder is more severe, it is as if their nervous system – at least that which modulates emotion – lacks any protective sheathing. Imagine trying to live your daily life with two layers of skin peeled off. Any mundane experience could bring agony.

When life is felt with such exquisite force, one's current emotions are inescapable. One manifestation of this is an "allergy to ambiguity." They see the world and the people in it as good and bad, perfect and foul. The person who has such character traits lives with the passion, but also with the lack of emotional resilience, like that of a toddler.

A Discussion of Sexual Abuse as It Pertains to Those with Borderline Personality Disorder

There is considerable evidence that the development of borderline personality disorder is due to a combination of emotional sensitivity (basic disposition) and an abusive/chaotic upbringing. They have very frequently experienced sexual and/or physical abuse as children. It is unknown if the abuse is a precipitant of the development of borderline character traits, or if the prevalence of abuse histories among such patients is due to predatory individuals seeking out already emotionally sensitive children.

Victims of abuse, particularly those with borderline traits, may frequently raise the subject of their abuse history. Some patients may have learned to use it as a tragic strategy to get some power in interpersonal relationships because people will "back off" when the subject is raised. For example, a psych tech who tries to set a limit with a patient may feel abusive when the patient cries and accuses her of being just like her father.

Most people, however, are not manipulative, even unconsciously. However, they may have been taught, as part of therapy, to speak about what they have learned is the source of their psychological distress and to explain why they are acting or feeling the way they do. Many people rush to comfort the person when they raise their history of abuse, particularly if they do so with strong emotions. Please recall that the individual with borderline character traits lives in the present moment. Therefore, whatever they feel right now is most important to them. This means that their abuse history may become a way of eliciting comfort. The problem, however, is that nothing is healed: their "wound" is merely reopened, and later, once the comforting person has left to attend to other tasks, the person may feel raw and exposed, or worry that the staff person will hold them in contempt or will reveal their information to anyone they choose. They then go into a crisis; perhaps they will even become suicidal.

For this reason, the issue of abuse requires sensitivity:

Report current abuse. If a patient reveals current abuse, then staff must, of course, follow protocols to ensure their safety and report the situation to the proper authorities, as necessary.

Stay in your lane. Staff need to be very clear on their professional responsibilities. If a patient decides that a staff person is trustworthy and for the first time reveals a history of physical or sexual abuse, the staff person should listen with caring and respect, long enough to understand, in general terms, what happened to the person. If the staff person does not have direct responsibility as a therapist for the patient, they should gently intercede, and tell the person that they have the utmost respect for the courage it must have taken to reveal this information. However, the staff person must further explain that it is important that they receive help from someone who is trained to give such therapeutic assistance. The next step would be to arrange for an appointment with a therapist properly trained in abuse issues, either on staff or as an outpatient referral. (Further details are contingent on the protocols of your hospital.)

When to engage in working on abuse issues. Of course, if you are the proper person to work with the person, both by training and role, then you should engage in therapeutic work. However, this, too, needs to be properly titrated, particularly if the person's hospital stay is short-term. Don't start something you cannot finish! Perhaps you will be able to arrive at an interim place in treatment and properly transition them to outpatient work.

Get a release of information. If the person has an outpatient therapist, hospital staff should endeavor to get a release of information, and follow the outpatient therapist's guidance on how best to make use of the patient's time while in the hospital. It is quite possible that the therapist will recommend that staff tell the patient that these are issues best discussed with their therapist upon their discharge from the hospital, and your response should be confined to, "And while you are here, we will focus on . . ."

Help the patient to develop a sense of privacy. If the patient repetitively or compulsively raises the subject, particularly with varied people, staff must be trained to say, "That is very personal information.

I am not trained to help you with that, and anyway, you are working on that with your therapist." On some occasions, I recommend that the staff person point out that in the past, when the patient has openly discussed abuse issues, they have subsequently spiraled into another crisis. One aspect of psychological health is a sense of privacy and proportion: this is particularly important for people who react so dramatically to negative emotions.

In maintaining the proper boundary in regards to this deeply painful history, you are showing the patient one of the finest human traits: tact. If it is not your business, or if you do not have the training to know how to respond to their account, the kindest thing is to (a) redirect them to their treatment plan and what they can accomplish in the hospital, and (b) guide them to people who can best help them, in a way that does not compromise either their overall treatment plan or their stay in the hospital.

Splitting

Because of this combination of character traits, individuals with borderline personality disorder frequently find themselves in various crises. Among them are suicidal attempts; parasuicidal acts (self-mutilating behaviors or repeat suicide "attempts" that were either gestures for effect or staged in a manner that despite the seriousness of the act, are found out; see Chapters 32 and 33); impulsive assaultive acts, particularly those involving family or other close relationships; and brief psychotic episodes. In essence, such a person believes that whatever feeling they are having right now is the only possible reality. For example, road rage is a borderline reaction: someone cuts a person off, it makes them mad, and instead of cooling down, they chase after them and smash into their car. On the flip side, they meet someone attractive in a bar, and within five seconds, they know that this is the love of their life.

In reaction to the dramatic and emergent events that so frequently occur in such individual's lives, many of the people associated with the patient, including their outpatient therapist(s), disagree about the most appropriate treatment course of action, even to the point of arguing about who is at fault for the patient's current crisis. Those involved in a therapeutic relationship with the patient often contextualize, explain, or excuse the behavior, especially when they have a previous history of trauma or abuse. When the individuals associated with a borderline person get tangled up in intense disputes about what is best for them, this type of conflict is called *splitting*.

The patient, although not entirely conscious of what they are doing, is at the center of the conflict, but it doesn't occur in a vacuum. You are also an integral part of it. Splitting should be regarded as a tactic in which the patient presents a different facet of their personality to each person with whom they interact. This "divide and confuse" strategy often sets family members, treatment providers, social services personnel, and legal system representatives against one another regarding the proper response to the patient's

behavior. It is a primitive defense mechanism that the individual develops in hopes of "disappearing": through engendering conflict, the significant figures in their life can never unite to focus on them. If one has an early history of chaos and abuse, such a strategy may provide a modicum of safety, at least compared to what might happen if everyone unified to negatively focus on them.

Although splitting is usually regarded as an "action" by the patient, one that is, at best, unconsciously manipulative and, at worst, sociopathic, this is too simplistic. Splitting is a process, not an act. Professionals are also participants in splitting, and quite frankly, sometimes the actions of these professionals *create* the splitting process. Not surprisingly, patients with borderline personality disorder will appear quite different to a therapist trying to build a supportive, non-confrontational relationship than to a psych tech or hospital social worker trying to help them negotiate their way through day-to-day life in the hospital, and a probation officer, who is most responsible for public safety and who can quickly take away the patient's freedom. Needless to say, each responds to the patient somewhat differently, and each may believe that they have the best idea on how to deal with them. Unfortunately, these varying opinions, and not coincidentally, a measure of professional pride, can lead to arguments about the best course of action.

In cases such as these, one or another party may decide to unilaterally make a decision based on what they believe is the patient's best interest. However, if all members of the defacto team responsible for the patient remain at odds, the "victory" by the person who made the unilateral decision will be short-lived. You will be working with the same people on other cases, and you will most likely continue to be "at odds/together" regarding this patient. Thus, whenever intense conflict or a divergence of opinions regarding a single patient arises, suggest the possibility of splitting and see if you can, by comparing observations, determine if the patient's interactions with various people have created the adversarial situation. The patient's case should be respectfully discussed among the treatment team to flesh out any necessary changes to the treatment plan. Without such consultation, an incredible amount of time and effort can be spent arguing about the status of one patient.

None of the above minimizes the seriousness of this character disorder or the genuine anguish that individuals suffer. At the same time, inappropriate or ineffective treatment, offered with the best intentions in the world, is not helpful. The following sequence is common:

- The individual presents in severe crisis, necessitating law enforcement and/or mental health professionals to intervene.
- They are taken to an inpatient unit. Often, after a period of resistance – which can include suicide attempts and assaultive or disruptive behaviors – the individual adjusts to the milieu.
- They are still seen as fragile, and this viewpoint is substantiated as treatment professionals interview the person. Issues of current or past abuse come up, and the person with the borderline disorder becomes emotionally volatile – with frequent mood swings, associated with "what comes up in therapy or group discussions."
- The patient becomes increasingly bonded to some practitioners, or even to the unit itself. In a very short time, it becomes a family system to them. As is typical with such individuals, they

may idealize one or another staff or patient, wanting to spend as much time as possible with them. Their need becomes consuming. At the same time, they may form a negative transference with other staff. This negativity is not mere dislike. In their all or nothing world, they idealize and they hate.

- Given that borderline splitting is an unconscious process, not only do staff evoke feelings simply by virtue of interacting with them, but also the borderline person may associate such feelings with images of family members or other people significant in their lives. Such feelings can be multilayered. The longer a borderline patient is in an inpatient unit, the more such feelings will be evoked. Splitting can be productively worked on in long-term therapy, where a patient is taught to become aware of their unconscious reactions and fantasies. But short-term inpatient facilities (drug-treatment or emergency hospitals) are not the places to do this family systems work.

Example: Borderline splitting with a patient

Samantha, a case manager, reminds the patient of her mother, whom she loved. She is, therefore, enraged with her because she never successfully stopped the abuse she suffered at the hands of her father. Eleni somehow reminds the patient of her second-grade schoolteacher, whom she disliked and who disliked her. It is equally possible that the patient is oppositional and aggressive to Eleni, or in an unconscious attempt to "do better this time," she is ingratiating and compliant.

- Problems frequently arise around discharge planning. Some staff may grow increasingly concerned because of the patient's volatility there is increasing fear that if the patient is released, they will come to harm, either by their own hand, or due to their interactions with others. If such discharge planning is brought up to the patient, they may become enraged – feeling rejected by their "family," and also cut off from those in the unit for whom they may have formed intense feelings. In some cases, they may be in the unit for months – with no improvement whatsoever in their basic level of functioning.
- Finally, familiarity breeds contempt. Staff are seen as toxic family members, jailers, or rejecting love objects. The end result is a pernicious cycle that culminates in assaults – sometimes very serious – on staff or other patients, serious suicide attempts, or a flare up of self-mutilating behaviors.

It is fair to say that in such a situation, the treatment facility has become a vector of psychological pathology. Without any ill intent, the hospital and its members constellate the behaviors that, clinically, we would hope to alleviate.

A Solution

Inpatient intervention for borderline personality disorder requires several components.

As this is a disorder of emotions, the intervention must focus on these areas. If a child receives the greatest amount of attention for negative behavior, he or she will increase those behaviors. It is the same for the individual with borderline character traits. Whenever the individual is disruptive and "acting out," interactions with staff should have some warmth, but should also be phlegmatic and brief. The patient's safety should be ensured, but verbal and emotional interactions should be short and "dry."

Given that borderline patients are quite reactive to other people's emotional reactions, staff's attitude should be similar to that of a perfect uncle or aunt. In undeviatingly enforcing the rules and paying attention to what is really going on, you are definitely an authority; but because you maintain a degree of emotional "distance," you don't get emotionally worked up.

An essential component of treatment is to assist the patient in managing the tension-relaxation cycle. It is not enough to teach the patient relaxation or stress-reduction exercises. One way to think of the borderline dilemma is to imagine an overtired child who "cannot settle." As they get tense, they feel like they will explode, but if they relax, they feel like they will fly apart. Therefore, the patient must be taught procedures that involve both the body and the breath, which give them a sense of control over their psycho-physical states, so that they can relax when tense *and* give themselves some tension (tensile strength) when overly loose or relaxed.[2]

Participation in activities on the unit – groups, recreation, and so on – is contingent on good behavior. As the patient begins to show mature behavior, emotional interactions with staff should increase, typified by warmth and approval.

Discharge planning should be initiated upon entry. With repeat patients who have numerous psychiatric emergencies, a wrap-around plan with outpatient services should be triggered upon entry.

The patient should be discharged as soon as they are stabilized. This can be as brief as a matter of hours or only a few days. Cure cannot happen within the inpatient unit. Improvement, even cure in some cases, occurs through enrollment in a comprehensive therapeutic program. In such cases, the inpatient unit functions as a crisis respite bed when the patient gets in situations that he or she cannot manage "outside." If the individual is kept at the hospital beyond stabilization, they will, as described above, begin to express their pathological style in reaction to the milieu. Rather than a respite, the hospital and its staff will become the triggers for new crises.

An effective program integrates the hospital as part of the treatment program. Therefore, individuals with borderline personality traits who are new to your local mental health system need to be enrolled, whenever possible, in an effective treatment program that is willing to work, hand-in-glove, with the hospital.

If your hospital program is too comfortable and "homelike," patients will make themselves "at home." Short-term respite units should be clean and well run, but not a place to make a nest. For example, I'm aware of some units where one sleeps in a comfortable easy chair rather than a bed. The message, given with kindness, is, "Don't make yourself at home."

You must be prepared for some patients to "flare" when they are treated differently than they may desire ("I'm upset and you are not comforting me!" is one example). They may escalate their behaviors, sometimes in very dangerous ways. Staff must be prepared for this. A hospital that cannot manage a borderline patient's disruptive, assaultive, or destructive behaviors cannot adequately serve such patients anyway. Colluding with the patient's pathological style is not therapy and will not help. Just as with a child who is used to getting what they want through public tantrums, borderline patients must be consistently treated with matter-of-fact strong discipline. Staff must maintain the protocols, even if some patients try to undermine them through an increase of pathological behaviors. Although the patient in the middle of his or her emotional storm may not agree, kindness and ethics are both best served when staff act in a way that will, in the long run, help the patient manage those storms better.

Even individuals who refuse to participate in an outpatient program should be subject to a protocol that includes the principles I have outlined. Such a protocol offers the patient the best hope that, in the future, they will engage in comprehensive services. It must be noted that this – alone – is *not* a protocol. I am merely describing some of the principles required in setting up a protocol.

Among "best practice" for those with borderline personality disorder is Dialectical-Behavioral Therapy (DBT), pioneered by Dr. Marsha Linehan of the University of Washington. Inpatient units that work with those with borderline personality would do well to consult with Dr. Linehan or another professional (or psychiatric hospital) fully trained in DBT methods.

Review: Working with those with borderline traits and dealing with splitting

- Stay focused on whether or not there is really an emergent issue.
- Do not be reactive to complaints or side issues the person brings up. Reward positive behaviors and deal with negative behaviors with an absolute minimum of emotion (thereby offering no reward). From your side, your emotional interaction should exemplify "warm distance."
- When abuse issues are raised, "stay in your lane." If you are not a therapist directly involved in their care, tactfully redirect them to their therapist – or work to help them get a therapist, who can actually assist them with this painful issue.
- Initiate discharge planning on admission.
- If they are a frequent admit to your hospital (or a resident in a group living situation), you will likely find yourself in a case that brings in players from many different systems and agencies; you must pool resources to arrive at a common viewpoint and plan for the patient.