INPATIENT PRACTICE

Borderline Personality: Get Staff on Same Page

Recently, a survey was conducted of psychiatric nurses in Dublin about their experiences with patients who had borderline personality disorder.

The nurses, who worked in inpatient and outpatient settings, reported that they felt ill prepared to handle patients with this disorder. One-quarter of the 67 nurses surveyed said they had daily contact with patients who had this condition, but only 3% of them had received any postgraduate training in bipolar personality disorder.

When they did receive training, it often consisted of a single seminar or workshop (J. Psychiatr. Ment. Health Nurs. 2007; 14:670-8). In all, 80% of the nurses said they thought these patients often received inadequate care.

About 20% of patients on general acute psychiatry units are patients with borderline personality disorder. Until fairly recently, these patients were thought to be beyond the reach of psychiatric practice.

But evidence now suggests that with intensive psychotherapy, such as dialectical behavioral therapy (DBT), patients with borderline personality disorder can show improvement, which translates into their needing less medication and attempting suicide less frequently.

This month, CLINICAL PSYCHIATRY NEWS speaks with Dr. John Oldham, chief of staff at the Menninger Clinic, Houston, about patients with borderline personality disorder on the inpatient unit. Dr. Oldham has a well-known and long-standing interest in personality disorders.

CLINICAL PSYCHIATRY NEWS: Many staffers who care for patients with borderline personality disorder on an inpatient unit tend to find these patients extremely difficult. What do you think explains that view?

Dr. Oldham: I think there are several parts to that. One reason is that many times patients with borderline personality disorder come to the inpatient unit because of a suicide attempt, so they have come to a point where they are extremely impaired and disabled.

They are struggling with intense emotions that are hard to control, and they often engage in self-injurious behavior. The inpatient staff often feel as if they cannot reach them and they get the impression that these patients are uncooperative. And the patients develop an unfair reputation.

I had one patient who described life with borderline personality disorder as "living without an emotional skin." These patients are extremely sensitive, and because of this they often do not do well with strangers.

A model pioneered in the United Kingdom involves 18 months of partial hospital treatment.

DR. OLDHAM

CPN: So caretakers tend to have this negative opinion of borderline personality disorder. Does that affect the care the patients get generally?

Dr. Oldham: It certainly can. These patients can behave in ways that may not conform to the usual expectations on the unit. The patients may be perceived as contrary and oppositional.

These circumstances can stir up countertransference reactions—such as reactivating difficult times with adolescent children or other family members—in any of us, which makes our work more complicated. It can be very hard to keep personal reactions separate, and to stay focused on understanding that the patient's behavior is driven by enormous internal stress. These patients take time, and they require individual attention.

The situation is made more complicated by the change in staff shifts throughout the day. What works best for the patient is having all the staff members on the same page. But sometimes they are not, and patients can go through a bad patch on a certain shift.

This often results in measures being taken that are designed to protect the patient, such as putting a patient on close observation to prevent self-injurious behavior. But such a move may not help patients learn to control their own impulses, may not lead to an exploration of the underlying distress, and may be perceived by patients as punitive.

It is important to remember that these patients describe getting relief when, for example, they cut themselves. I think we need to understand that.

CPN: The perception of borderline personality disorder has changed in recent years. Patients with this condition are now perceived to be treatable. Is this new perception justified?

Dr. Oldham: It is definitely justified. We actually have a pretty optimistic view about the potential for improvement and capacity for these patients to do well when they can get good treatment. The problem is that nobody has come up with a quick fix yet.

The American Psychiatric Association's practice guideline for the treatment of borderline personality disorder is actually the only association guideline for which the evidence base recommends psychotherapy as the primary treatment.

The psychotherapy is usually a combination of individual therapy and group skills training, preferably given more than once a week, and it can take up to a year. When patients can do that, they frequently benefit enormously. Unfortunately, patients often do not have enough resources to support an adequate length of treatment.

CPN: Some of this intensive psychotherapy has been done in an inpatient or day-hospital setting. Is hospitalization necessary? Does it have advantages?

Dr. Oldham: That is a model that has been pioneered in the United Kingdom, with 18 months of partial hospital treatment. The treatment in that program involves a psychodynamic model that is very different from a DBT approach. But both programs have shown good results.

CPN: The recent study from Ireland, in which psychiatric nurses were surveyed, found that they had much contact with borderline personality disorder, but little specific training. Is the situation similar here?

Dr. Oldham: I think there are lots of times that we could find similar situations here. Many psychiatric units—and particularly acute care units—are caring for many different kinds of patients. So the staff does not get the training that might help them to better understand this disorder.

On the flip side, however, there is more recognition of the progress being made in understanding these patients.

In addition, there are more places where people do acquire some familiarity with DBT training, for instance, and can incorporate that knowledge in how they care for patients.

CPN: In all, 20% of inpatient psychiatric patients are thought to have borderline personality disorder. What can happen with those patients in the short amount of time that they spend on an acute unit? And does that happen generally?

Dr. Oldham: Brief hospitalization can decompress a crisis. Patients with this disorder are very reactive to interpersonal stress. So in a heated situation, these patients can be at serious risk for suicide, which is the cause of death in about 10% of these patients. They need to have a brief clinical respite, and that alone can be helpful.

It can also help if the staff has an understanding of these patients. And working with that understanding can help the staff address the safety concerns that are paramount and help them reinforce the patient's need for ongoing continuity of care.

After all, the real work is going to have to be done on an outpatient basis. ■

By Timothy F. Kirn, Sacramento Bureau. Send your thoughts and suggestions to cpnews@elsevier.com.

Survey Shows Support for Employer-Based Health Insurance

BY MARY ELLEN SCHNEIDER
New York Bureau

Most Americans favor a continuation of the employer-based health insurance system and say that they believe health insurance costs should be shared among individuals, employers, and the government, the results of a survey conducted by the Commonwealth Fund show.

More than two-thirds of Americans who took part would favor a mandate for individuals to obtain health insurance in an effort to provide universal health coverage.

These findings indicate that on certain health reform issues Americans' views may be more closely aligned with the proposals put forth by Democratic candidates for president than those outlined by Republicans.

For example, the leading Democratic candidates would require employers to offer health coverage to employees or pay for part of their coverage, while most of the Republican candidates are proposing changes to the tax code that could potentially reduce the role of employers in the health insurance market, according to a Commonwealth Fund analysis.

Sen. Hillary Clinton (D-N.Y.) and former Sen. John Edwards (D-N.C.) would support an individual insurance mandate, while Sen. Barack Obama (D-Ill.) would mandate coverage for all children.

Of all the Republican candidates, no one is proposing an individual insurance mandate, according to the Commonwealth Fund.

From June to October 2007, the Commonwealth Fund conducted a telephone survey of 3,501 adults aged 19 years and older as part of its biennial health insurance survey. The group released the results from four health reform queries before they announced the other findings, which are scheduled to be released in March.

The survey respondents expressed broad support for an employer-based system of health insurance coverage. About 81% of respondents said that employers should either provide health insurance or contribute to a fund in order to cover all Americans. Support for this idea among respondents was high regardless of political affiliation, race, gender, age, and income.

The support for an individual insurance mandate to ensure coverage for all was lower; 68% of the respondents said that they strongly or somewhat favor a requirement that all individuals obtain health insurance. About 25% said they strongly or somewhat opposed the idea. About 7% said they didn't know, or refused to answer.

When respondents were asked who should pay for health insurance for all Americans, 66% favored a system in which costs would be shared by individuals, employers, and the government. About 15% said it should be mostly government financed, 8% said it should be paid for mostly by employers, and 6% favored having individuals pick up the tab.

An additional 5% said they didn't know, or refused to answer. ■