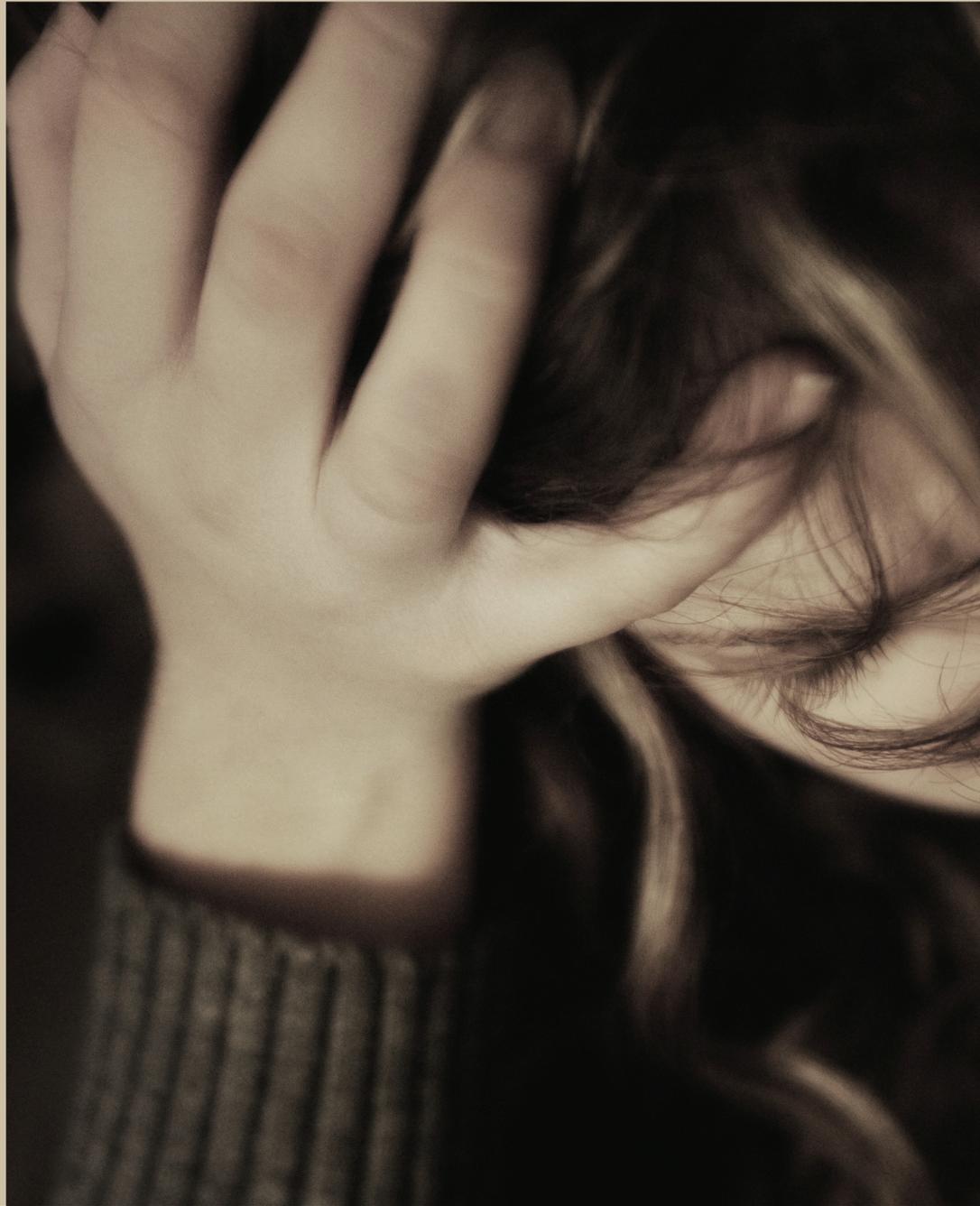


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## ABSTRACT

Psychotherapeutic treatment of people with borderline personality disorder (BPD) is one of the greatest challenges confronting mental health professionals today. Clients with BPD are often difficult for nurses to work with, perhaps due to a lack of understanding of the underlying dynamics of the disorder. This article describes effective treatment strategies for BPD with a central focus on dialectical behavioral therapy (DBT). In typical mental health settings, nurses can effectively implement interventions using the concepts of DBT to help people with BPD build effective coping strategies and skillful behavioral responses for improved quality of life.





# Borderline Personality Disorder

## *Nursing Interventions Using Dialectical Behavioral Therapy*

### **CLINICAL VIGNETTE**

Ms. K. is a 34-year-old woman diagnosed with borderline personality disorder. This is her fourth admission to the psychiatric outpatient hospital program, with symptoms of depression and self-abuse. She has a long history of outpatient mental health treatment with medication to control mood swings, and experiences migraine headaches, which tend to increase in frequency when she feels alone. Despite her symptoms, Ms. K. currently remains employed; however, she has been having trouble functioning at work and at home where she lives alone in an apartment in a small rural community. The treatment team is exploring which treatment approach to use with Ms. K. when planning her care. Ms. K. states she is upset over a job promotion that she did not get at work and is feeling alone and abandoned. She begins to experience a migraine headache.

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Psychotherapeutic treatment of clients with borderline personality disorder (BPD) is one of the greatest challenges confronting mental health professionals today. Labeled a psychosocial epidemic, BPD is one of the most widely studied psychiatric disorders and the most extensively researched personality disorder (Louw & Straker, 2002). Little research has been conducted

dynamics of the disorder. Traditional treatments for BPD have included a variety of approaches, including pharmacological, individual or group therapy, and hospitalization.

This article describes effective treatment strategies for BPD, with a central focus on dialectical behavioral therapy (DBT), which can be used successfully by nurses at all levels of education. Dialectical behavioral therapy

Association [APA], 2000). It is also more common among first-degree biological relatives of those with the disorder, which may indicate a genetic link (APA, 2000). Environmental influences are paramount. Up to 91% of clients with BPD have experienced high rates of childhood trauma. Early separation experiences and emotional withdrawal from early caregivers are common. Other risk factors include physical or sexual abuse and witnessing domestic violence (Dean, 2001).

### CLINICAL FEATURES

Formally introduced in 1938 by Stern, the term "borderline" refers to a group of disorders between neuroses and psychoses (Louw & Straker, 2002). The APA (2000) describes BPD as a pervasive pattern of instability of interpersonal relationships, self-image and affect, and marked impulsivity beginning by early adulthood and present in a variety of contexts. All criteria are of equal diagnostic significance (Louw & Straker, 2002). According to the APA (2000), definitive diagnosis requires five or more of the following features:

- Frantic efforts to avoid real or imagined abandonment.
- A pattern of unstable and intense interpersonal relationships, characterized by alternating between extremes of idealization and devaluation.
- Identity disturbance: markedly and persistently unstable self-image or sense of self.
- Potentially self-damaging impulsivity in at least two areas (e.g., spending, sex, reckless driving, substance abuse, binge eating).
- Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.

**Based on a U.S. population of approximately 250 million, it is estimated that 5 to 10 million people have borderline personality disorder.**

concerning empirically based treatment for BPD, so little is known about the efficacy of psychological interventions for borderline pathology (Louw & Straker, 2002).

The following questions should be carefully considered when defining treatment strategies for Ms. K.:

- What behavior problems is Ms. K. experiencing that are central to planning treatment and nursing interventions?
- What are the main objectives when planning treatment outcomes? It is important that Ms. K. and the treatment team collaboratively identify objectives when considering the difficulties Ms. K. is experiencing.
- What treatment strategies would be most effective when planning care for Ms. K.?

Clients with BPD are often difficult for nurses to work with, perhaps due to nurses' lack of understanding of the underlying

skills training may be presented to clients in a group format or individually in a variety of psychiatric settings. The client and treatment team collaborate to monitor and implement behavioral change.

### PREVALENCE AND ETIOLOGY

Borderline personality disorder has been identified in many settings around the world. Epidemiological studies of adults show that BPD prevalence rates range from 0% to 7% in Norway to 1% to 8% in the United States (Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004). Based on a U.S. population of approximately 250 million, it is estimated that 5 to 10 million people have BPD. People are diagnosed with BPD most often between ages 19 and 34 (Dean, 2001). Approximately 75% of people diagnosed with BPD are women (American Psychiatric

- Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, anxiety) that usually lasts a few hours and only rarely more than a few days.

- Chronic feelings of emptiness.

- Inappropriate, intense anger or difficulty controlling anger. This may be exhibited in the form of frequent displays of temper, constant anger, or recurrent physical fights.

- Transient, stress-related paranoid ideation or severe dissociative symptoms.

## PSYCHOPATHOLOGY

Magnetic resonance imaging (MRI) studies have demonstrated structural abnormalities of the brain in people with psychiatric illnesses (Lyo, Moon, & Cho, 1998). A recent MRI study using volumetric measurement evaluated structural abnormalities of the brain in people with the sole diagnosis of BPD. Unlike clients who frequently have histories of comorbidity with other Axis I or II disorders, these patients were more likely to represent brain abnormalities of BPD. Using healthy comparison patients matched for age and gender, it was found that people with BPD had a significant decrease in frontal lobe volume, compared to comparison patients.

Neuropsychological and positron emission tomography studies in people with BPD have reported functional abnormalities in the frontal lobe of the brain, including impairment in cognitive and executive functioning, as well as altered metabolism in the prefrontal region (Lyo et al., 1998). Interestingly, it has been reported that impulsivity is closely related to frontal lobe dysfunction in people with personality disorders. It is also known that

patients with frontal lobe damage have had problems with impulse control (Lyo et al., 1998). These findings may provide a basis for understanding BPD and may lead to improved treatment outcomes.

## TREATMENT METHODS

Lieb et al. (2004) reported that during a lifetime, 97% of people with BPD in the United States receive treatment in the form of outpatient care. Outpatient treatment may include individual, family, or group therapy, and partial hospital-based day treatment programs. However, research suggests that these treatments are marginally effective (Lieb et al., 2004).

Historically, these treatments have been based on frameworks such as psychodynamic theory, which postulates that inner emotional conflicts are the basis of behavior (Dean, 2001). Considering the structural abnormalities of the brain found in MRI studies and the associated behaviors of BPD, effective treatment for the disorder must be client focused and individually based. Dialectical behavioral therapy provides change strategies to help clients with dysfunctional behaviors unique to this vulnerable population and to learn new ways of interpreting life events.

## Cognitive-Behavioral Therapy

The cognitive model of personality, developed by Aaron Beck, serves as the foundation for cognitive-behavioral therapy (CBT) (Brabender, 2002). This theoretical approach asserts that behavior is a result of how individuals conceptualize the world and what meaning they attach to events. This is true for clients with BPD. Cognitive distortions may cause intense feelings and

behaviors that are the result of clients' perceptions of events. In the case of Ms. K., she did not get the job promotion she was hoping for and then concluded that she will never get a promotion, no matter how hard she tries. This type of "all-or-nothing" thinking contributes to a distorted view of self and events that may bring about painful feelings of failure.

The cognitive model ascertains that clients' experiences in early life serve as a guide through which they view and interpret life events. Important significant others in a child's life, such as parents, teachers, relatives, and friends, help shape one's understanding of events and, therefore, one's beliefs. These fundamental beliefs are integrated into the self and bring powerful thoughts, emotions, and behaviors to the forefront. One predominant feature of BPD is a history of previous negative experiences in early life, such as childhood abuse, that shape distorted thoughts, beliefs, and impaired behaviors in the here and now. Such experiences may foster feelings of fear of abandonment, such as in the case of Ms. K.

When planning care for Ms. K., it is important to focus on nursing interventions that will increase her self-esteem and improve coping, communication, and problem-solving skills, while decreasing suicidal thinking and behaviors. The goal of CBT is to provide symptom relief by modifying clients' thoughts and conditioned beliefs and helping them acquire the skills needed to evaluate such, and in turn, promote well-being (Brabender, 2002). Collaboratively building nursing interventions based on CBT can empower Ms. K. to improve her interpersonal

skills, decrease her maladaptive behavior patterns, and improve her overall functioning.

### **Dialectical Behavioral Therapy**

Improving interpersonal skills, decreasing maladaptive behavior patterns, and improving overall functioning are the main goals of DBT in the treatment of BPD. Dialectical behavioral therapy is a form of CBT (Swenson, Torry, & Koerner, 2002) based on dialectics, the practice of logical discussion. It is a strategy used by the client and nurse together to facilitate change, when applied for the treatment of BPD. Dialectical strategies are presented in psychosocial skills modules similar to those in other CBT strategies (Linehan, 1993a). Outcome studies have shown that DBT has been instrumental in reducing inpatient hospitalization, parasuicidal episodes, and interpersonal dysfunction (Linehan, 1993a; Nehls, 2000).

Dialectical behavioral therapy is a psychosocial treatment demonstrated to be successful for BPD. A randomized controlled trial conducted by Safer, Telch, and Agras in 2001 compared the outcomes for 31 women with bulimia nervosa who received 20 weeks of individual DBT or were assigned to a waiting list. They found that the women who received DBT experienced significant decreases in binge and purge behaviors, compared to the clients on the waiting list (as cited in Swenson et al., 2002).

### **NURSING INTERVENTIONS USING DBT**

Psychosocial skills training, essential to DBT, may be presented in a group format or in individual therapy, when clients

cannot attend or are inappropriate for groups. At times, a DBT group may not be available. In a private practice or small clinic, there may be only one client who needs skills training at any given time. Some clients may have already participated in skills training and may need further intervention in specific categories. The modules can be selected

## **Improving interpersonal skills, decreasing maladaptive behavior patterns, and improving overall functioning are the main goals of dialectical behavioral therapy in the treatment of borderline personality disorder.**

according to client need. Skills training may also be viewed by clients on videotape (Linehan, 1993b). Whether working with clients in groups or individually, collaboration with the treatment team is necessary for nurses to monitor clients' progress and provide ongoing supervision and support.

Dialectical behavioral therapy skills are relatively easy to learn and use. The skills modules can be learned from videotapes, in-

dividual instruction, role play, or text and manual forms that include session-by-session outlines by Linehan (1993b). In a group format, two group leaders usually conduct the sessions. If working individually, the nurse and client collaborate together on the skills modules, and later, the nurse collaborates with the treatment team.

Outcome objectives focus on increasing positive behaviors, such as decreasing impulsivity and suicidal or self-harm activities. This is important in the case of Ms. K., as she had a history of self-abusive behavior. Treatment objectives also aim to increase clients' ability to tolerate stress, manage strong emotions, and increase self-respect. Teaching coping skills will help Ms. K. learn to tolerate stress and help minimize her migraine headaches. Skills training focuses on four essential behavioral skills that clients with BPD are unable to produce. These skills, drawn from Eastern meditation practices are:

- Mindfulness.
- Interpersonal effectiveness.
- Emotion regulation.
- Distress tolerance.

### **Mindfulness**

*States of Mind.* Mindfulness is central to DBT and includes three major states of mind: reasonable mind, emotional mind, and wise mind. Reasonable mind is the ability to remain calm, gather facts, and use rational problem solving. Reasonable mind involves interventions with Ms. K. that help her approach problems intellectually and rationally, while deciding on appropriate behaviors to handle difficult situations at home and work.

Emotional mind is thinking and behavior based on clients'

current emotions. When admitted to the hospital, Ms. K. was using emotional mind: her thinking and behavior were emotionally based, and it was difficult for her to be reasonable and think logically.

Wise mind is the joining together of reasonable mind and emotional mind. Wise mind is knowing the truth about something by logically thinking it through or observing it to be true. Effective problem-solving abilities are needed on a daily basis for clients with BPD to take charge of difficult life events.

*“What Skills.”* There are three mindfulness “what skills” that involve learning to observe, describe, and participate with awareness. Participating without awareness involves behaviors driven by mood and impulsivity. The “what skill” of observing is giving attention to behavior, emotion, and events while not attempting to end them when they are unpleasant. Helping Ms. K. experience whatever is happening to her, even when the emotion is painful, will help her decrease her behaviors of avoidance and fear.

A second “what skill” is the ability to describe behaviors and events, which is necessary for both communication and self-control. People with BPD often confuse emotional feelings with precipitating events, and physical components of fear often produce dysfunctional thoughts, as well as thoughts that are confused with facts. In the case of Ms. K., she experienced migraine headaches and felt alone and abandoned. The dysfunctional thought here was “I am alone and abandoned.”

The third “what skill” is the ability to fully participate in an activity. When encountering new situations at home and work, Ms.

K. can use the skills of observing and describing to understand events and participate in life accordingly.

*“How Skills.”* There are three “how skills” that include looking at things nonjudgmentally, doing things in the moment, and doing what is effective. Looking at life events and one’s self nonjudgmentally after observing and describing is an important skill.

their own perceptions, judgments, and decisions.

### **Interpersonal Effectiveness**

When using interpersonal effectiveness, the goal is to learn skills for interpersonal problem solving. The focus is on interpersonal conflicts, such as problems with relationships, anxiety, and issues of abandonment. Social and assertiveness skills are applied and

**One goal of dialectical behavioral therapy is to learn to tolerate and accept distress as a part of life.**

It is imperative to help Ms. K. take a nonjudgmental approach when appraising events. A nonjudgmental stance will allow her to observe the consequences of her behaviors and have the freedom to change, but not label the behaviors as good or bad.

The second “how skill” is focusing on one thing in the moment, which requires full attention on the activity. For example, when using this skill, clients separate tasks, such as worrying, to a different time. If a separate time for worrying is set aside, clients will be able to give their full attention to other tasks when they occur. Focusing on one thing in the moment will help Ms. K. attend to the task she is working on, instead of being distracted by troubled thoughts.

The third “how skill,” is being effective and is aimed at reducing clients’ tendency to dwell on doing what is right, rather than what is actually needed. This is useful in helping clients trust

include asking for what one needs, saying no, coping with conflict, maintaining a relationship with another person, and maintaining self-respect. When applying interpersonal effectiveness skills, Ms. K. can increase her coping skills while building self-confidence to manage her feelings of loneliness and despair.

### **Emotion Regulation**

The third essential skill of DBT, emotion regulation, focuses on increasing control of emotions, and identifying and describing emotions. Helping Ms. K. to learn to understand her emotions, reduce her vulnerability, increase her positive emotions, and let go of her painful emotions is key. These skills allow Ms. K. to manage her feelings of abandonment, thus increasing her self-esteem.

### **Distress Tolerance**

The final skill of DBT, distress tolerance, aims at tolerating and

surviving crisis situations. One goal of DBT is to learn to tolerate and accept distress as a part of life. Crisis survival strategies include distraction from distress; improving the moment through prayer, imagery, or relaxation; self-soothing through the five senses; and thinking of the pros and cons of tolerating the distress. These skills will prepare Ms. K. to handle future crisis

2003). Study findings indicated that clients experienced a significant decrease in anxiety and depression, and perceived that DBT helped save their lives. Previously suicidal clients said they had new hope for the future after treatment with DBT and felt a sense of respect and understanding they had not experienced with other types of psychiatric care. Results also showed that

perceptual difficulties (e.g., hallucinations, paranoid ideation). Finally, polypharmacotherapy may be useful in decreasing symptoms and improving quality of life (Lieb et al., 2004).

## CONCLUSION

While helping clients with BPD remains a challenge for health care providers, empirical evidence indicates that DBT is an effective treatment for BPD. Dialectical behavioral therapy is easy to implement, offers immediate symptom management, and is cost effective. In typical mental health care settings, nurses can effectively implement interventions using DBT either in groups or individually to help clients with BPD achieve optimal wellness. Collaboration with the treatment team is necessary for monitoring clients' progress and treatment. Helping clients with BPD build effective coping strategies and skillful behavioral responses are key elements for improved quality of life.

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**[In a qualitative study], previously suicidal clients said they had new hope for the future after treatment with DBT and felt a sense of respect and understanding they had not experienced with other types of psychiatric care.**

situations. Changing behaviors during crisis situations is key (Linehan, 1993b).

## INTERVENTION USE

When using DBT skills modules from the manual by Linehan (1993b), a step-by-step guide is used with handouts and homework assignments for each skill. Clients also complete diary cards each week, which help nurses and clients monitor behaviors during the week and identify any behaviors that may be interfering with therapy. The cards include a rating for topics such as suicidal ideation and self-harm. There are also blank columns to record other behaviors, such as hours doing DBT homework and exercise. Diary cards can be used in either group or individual therapy.

In a qualitative research study, clients with BPD were interviewed to explore the usefulness of DBT (Perseus, Ojehagen, Ekadahl, Asberg, & Samuelsson,

clinicians believed DBT helped clients lead more independent lives and become more responsible, decreased self-harm, and improved social functioning (Perseus et al., 2003).

## BPD AND PHARMACOTHERAPY

Many clients with BPD are taking psychotropic medications as adjunctive treatment. For clients with BPD, pharmacological intervention may be useful for treating target symptoms, such as emotional dysregulation, impulse control problems, or cognitive perceptual difficulties. Antidepressant agents may play a role in decreasing symptoms of anxiety, anger, mood shifts, and dysphoria. Although studies show mixed results, mood-stabilizing agents, such as valproic acid (Depakene®), may be used for people with BPD with impulsive aggression. Neuroleptic agents may effectively treat cognitive

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## KEY POINTS

1. One of the greatest challenges confronting mental health professionals today is selecting a successful psychotherapeutic treatment for borderline personality disorder (BPD).
2. Empirical evidence indicates that dialectical behavioral therapy (DBT) is an effective treatment strategy for BPD. DBT is easy to implement, offers immediate symptom management, and is cost effective.
3. Essential components of DBT include mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance.
4. In typical mental health settings, nurses with all levels of education can skillfully implement interventions using DBT to empower people with BPD to develop effective coping strategies and skillful behavioral responses for improved quality of life.

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