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Crisis Management for Patients with Borderline Personality Disorder

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PERMISSION

Title Crisis Management for Patients with Borderline Personality Disorder

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Abstract

Borderline personality disorder (BPD) is characterized by mood instability, emotional dysregularity, lability in interpersonal relationships, pervasive issues with self image, and behavioral issues (National Alliance on Mental Illness, 2011). Many patients with BPD exhibit self-injurious behavior that may or may not be suicidal in nature. This aspect of BPD is often times what leads to inpatient hospitalization. There is no proven benefit in hospitalizing patients presenting with this behavior, and some say it even has adverse outcomes for the patient (Berrino, et al., 2011; Paris, 2004). Patients with this specific diagnosis make up a large portion of those utilizing mental health services, and therefore more focus needs to be placed on ensuring that the services in place are appropriate and provide the most effective interventions possible. This project explored the options for interventions when treating patients with BPD to determine the most effective interventions for care providers to utilize when a patient presents in an acute crisis. The information gathered from the literature search and from the examination of current programs was compiled and presented to staff at an inpatient behavior health unit to examine the options of creating a formal crisis management plan. After presentation and discussion, it was decided that there was not sufficient evidence for implementation of a crisis management plan at this time, but that several people were interested continuing to research the topic.

Crisis Management for Patients with Borderline Personality Disorder

Introduction

Personality disorders are among the most challenging disorders for mental health nurses and providers to manage, and management of borderline personality disorder (BPD) can be especially difficult because of the behaviors that patients may exhibit. BPD is a "serious mental illness characterized by pervasive instability in moods, interpersonal relationships, self image and behavior" (National Alliance on Mental Illness, 2011, para. 1). Emotional dysregularity and lability often leads to disruptions in family, personal, and professional relationships. The intense emotions that are often exhibited also may lead to self-harm and/or recurrent suicidal behavior. Diagnosis by a health care professional is based on meeting five of the nine criteria as identified in the DSM IV, which is one of the reasons why patients with BPD can present so differently from one another. All of these patients need to be properly diagnosed in order to receive proper treatment (National Alliance on Mental Illness, 2011). It is thought that two to three percent of the population in the United States meets the criteria set forth for BPD, and that 10 percent of patients who utilize outpatient services and 20 percent of those who are hospitalized on inpatient mental health units carry the diagnosis of BPD (Friedman, 2008).

Self- harm behaviors are many times the most difficult aspect of BPD to manage as a mental health care provider. Seventy five percent of patients with BPD engage in self-harm behaviors such as cutting, burning, hair pulling, and head banging, and it is believed that the physical pain is used to relieve the intense emotional pain that one is feeling. According to the National Alliance on Mental Health (2011), "the release of endogenous opiates provides a reward to the behavior" (para. 16). This behavior is sometimes referred to as parasuicide as it is nonlethal and the patient has no intention of dying while harming themselves. Suicide gestures

manifestations not only affect those with the behavior, but also those around them. It can have devastating effects on families, friends, and the community they are a part of. It is currently estimated that about two percent of the population meet diagnostic criteria for BPD (Borschmann, Henderson, Hogg, Phillips, & Moran, 2012).

According to Borschmann and Moran (2011) patients with borderline personality disorders often find themselves in states of crises that may include "a clear precipitating event causing acute anxiety and emotional suffering; an acute reduction in motivation and problem-solving ability; and an increase in help-seeking behavior" (p. 18). During these times patients often seek the help of their current providers or present to the emergency room of a local hospital. Currently, there are few studies that specifically address crisis management for patients with borderline personality disorder, but those that have been done show promising results. Several previous studies indicate that a crisis intervention program that includes psychotherapy and involves the patient's support system has been effective in reducing the rate of hospitalization as well as decreasing acts of self harm (Berrino et al., 2011).

A comprehensive and systematic approach to crisis management can potentially reduce suicide attempts, improve one's quality of life, and decrease the amount of inpatient hospitalizations. Providers in the areas of psychiatry, general practice, community and public health areas, and emergency services will be the most impacted by the management plan being introduced, but providers in all areas can benefit from learning the management skills as these patients are seen in all areas of health care. The review of literature that has been done for this project has provided insight into the benefits of a crisis management plan for providers and patients, and outlines the strategies that can be implemented during times of crisis. By forming a comprehensive management strategy, that includes identification of the crisis, thorough

assessment of the safety risks to the patient, identification of appropriate coping skills, and assessment of social and community support resources, the provider will be able to determine whether hospitalization is necessary or whether outpatient follow-up can be arranged.

Theoretical Framework

The Planned Change Theory developed by Kurt Lewin has been utilized in this project to provide structure and enhance understanding of the topic and related concepts. The Planned Change Theory has helped to guide this project because of the significant change one with BPD must go through to help improve the manifestations that can plague them such as acts of self harm, troubles with interpersonal relationships, and emotional lability. Patients with BPD have lived their life using maladaptive coping skills and they often need intensive intervention to make the change to positive coping skills. These interventions can be carefully planned and implemented with the Planned Change Theory in mind.

Lewin's theory is based on the notion a planned change is one that is designed and moves something from the status quo and is influenced by driving forces and restraining forces. The driving forces are those that promote movement towards a goal or outcome, and restraining forces are those that have the opposite effect and impede the progress towards the goal or outcome (McEwen & Wills, 2011). Both driving and restraining forces need to be identified and anticipated in order to accentuate the driving forces and minimize the effect of the restraining forces.

This theory also involves a three stage process that is necessary if the goal of change is to be attained: unfreezing, moving, and refreezing (McEwen & Wills, 2011). During the unfreezing period it is important for those involved to become aware of the need for change, understand the process of change, and to agree that the change being proposed is necessary. For

example, when working with patients with BPD, it is important to examine the issues in their lives that are influencing the state of crisis, lay out the plan for crisis management, and to allow them to make the decision to change. The provider can help the patient find a new method to let go of patterns of behavior that have been previously counterproductive. If they are not committed to the change or resistant in any way the interventions will not be successful.

The second stage involves moving from the status quo to a new state where the change has been made. This includes "a process of change in thoughts, feeling, behavior, or all three, that is in some way more liberating or more productive" (Current Nursing, 2011, stages). During this time the crisis interventions will be implemented and the patient will work the provider to decrease the stress of the crisis at hand. The driving forces need to be more prevalent than the restraining forces during this stage and it must be understood by all involved that change does take time so as to not get frustrated or give up. The final stage, refreezing, is when stabilization occurs and the changes have taken place. It is important during this stage to establish the changes made as a new habit, one that will now be the new status quo. It may take many encounters with the patient to achieve the goal of refreezing or changing the behaviors that lead to crisis, but without this it is easy to revert back to a time before the change.

Definitions

In order to have a comprehensive understanding of the topics being discussed throughout this project it is important to clearly define them.

Borderline personality disorder

Criteria for the diagnosis of borderline personality disorder as described by New York-Presbyterian: The University Hospital of Columbia and Cornell (n.d.) includes "a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked

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impulsivity beginning by early adulthood and present in a variety of contexts" (para. 2). The Diagnostic and Statistical Manual of Mental Disorders-IV states that five or more out of nine criteria must be met in order to officially diagnose one with BPD. The themes in these criteria include avoiding abandonment, splitting in interpersonal relationships, identity disturbance, impulsive behaviors, recurrent suicidal behaviors or self-harm, affective instability, feelings of emptiness, anger issues, and stress-related paranoia (New York-Presbyterian: The University Hospital of Columbia and Cornell, n.d.). BPD cannot be officially diagnosed until the age of 18, but many times the manifestations are seen in adolescence.

Crisis

One of the definitions of crisis by dictionary.com (2010) is "a dramatic emotional or circumstantial upheaval in a person's life" (para. 1). This definition as related to patients with BPD is when a precipitating stressor causes acute anxiety and overwhelming emotional suffering. During this time patients often experience a reduction in their ability to problem-solve and an increase in their behavior intended to elicit the help of others (Borschmann & Moran, 2011).

Suicide and Suicidal Behavior

Suicide is "the act of taking one's own life on purpose" (U.S. National Library of Medicine and National Institutes of Health, 2012, para. 1). Therefore, suicidal behavior is any action that could lead to the completion of suicide such as hanging, drug overdose, or cutting one's wrist. Most often, people who attempt suicide are trying to escape a situation in life that seems too overwhelming or hopeless and they cannot find other ways to deal with the stressor. These overwhelming emotions are often acute, but people can have lifelong thoughts or ideations

about suicide (U.S. National Library of Medicine and National Institutes of Health, 2012). This behavior is common in patients with BPD because of the crises they often find themselves in.

Self-harm or self-injurious behavior

According to Mayo Clinic (2010), "self-injury is the act of deliberately harming your own body such as cutting or burning yourself" (para. 1). Self-injurious behavior by definition is not meant as a suicide attempt, but rather an unhealthy coping mechanism to deal with stress, pain, anger, and frustration. Many patients with BPD participate in these behaviors in times of crisis, and in some cases is a reach out for help.

Review of the Literature

At this time there is a limited amount of research that has been done that is focused on management of patients with borderline personality disorder during a time of crisis, but by examining the evidence that is present, and other studies with components helpful during crisis intervention, a comprehensive management strategy can be formed. One of the reasons that there has not been extensive research done on borderline personality disorder done in the past is that it was often thought that patients with borderline personality disorder were not capable of getting better and that the manifestations that were present were untreatable, but now mental health professionals know differently and there are several treatments that have been found to be effective. Although there are effective treatments available, patients with BPD may continue to experience times of overwhelming stress and often present to health care providers in time of crisis. It is important to have a plan in place on how to intervene during these times.

Self-harm and suicidal behavior

Patients with BPD commonly engage in self-harm behavior as a way to cope with difficult emotions and life events and it is important for health care providers to develop a better

understanding of why this is. According to Maddock, Carter, Murrell, Lewin, and Conrad (2010), "understanding the range of reasons given for deliberate self-harm by those who engage in it may help reframe more helpful, less pejorative and more accurate attitudes towards all patients with non-fatal suicidal behavior" (p. 581). Reasons for self-harm vary from person to person and it is a dangerous coping strategy used in times of crisis or distress when they have not been able to utilize more healthy and constructive management strategies. Many times it is used to punish oneself, stop bad feelings, relieve feelings of emptiness, to feel something other than emotional pain, and to gain control over some aspect of their life (Maddock et al., 2010; Barbe, Rubovszky, Venturini-Andreoli & Andreoli, 2005).

Self-harm behaviors are often times confused with suicidal behaviors because they may appear to be the same types of injury or action, but there is a difference and it is import to assess the patient's intentions regarding their presentation. Suicide attempts are made by the patient with at least partial intention of completion and ultimately taking their own life. Self-harm is done without the intention of dying, but for many of the reasons listed above (Barbe et al., 2005). It would be negligent on the part of the provider to assume that patients with BPD are not at risk for suicide and that the self-harm behavior they exhibit is about getting the attention they are seeking. Many times the self-harm behaviors are the only way patients know to get the help they need during times of crisis, and it is important that providers can assess and recognize this to develop a treatment plan appropriate during these times.

Crisis Management

Patients with BPD are at a high risk for suicide due the impulsivity of their behaviors and the self-harm they often in engage in during times of crisis. Crises often occur when patients experience adverse life events, often precipitated by the emotional lability and impaired

interpersonal relationships related to the disorder, and their impaired problem-solving and use of negative coping skills lead them to a place that is overwhelming and further exacerbates the crisis (Borschmann & Moran, 2011). Behaviors that are often seen during times of crisis include suicidal and homicidal threats, self-harm, anger and aggression towards others, and impulsivity (National Collaborating Centre for Mental Health, 2009). During this time, patients will often present to their psychiatrist's office, the emergency room, call for emergency services, or be in contact with a mental health crisis line, so it is vitally important that providers understand the crisis, and have the tools they need to make decisions regarding further care.

Many facilities, including the one where this project will first be presented to, do not currently have formal crisis management plans in place. This often results in inpatient hospitalization, which in some cases could be prevented with proper crisis intervention. The National Collaborating Centre for Mental Health (2009) suggests that admission to the hospital without the proper assessments may in fact hinder one's ability to improve problem solving skills and develop the proper coping skills needed in order to deal with crises in the future. The assessment of a patient in crisis can be a daunting task because of the risk involved related to the patient's behaviors and actions, but it is crucial that that a thorough assessment be conducted. Assessment should be done and management of the crisis should take place "without acting in ways that are experienced by the patient as invalidating or minimizing their problems, while at the same time, fostering autonomy" (NCCMH, 2009, section 7.1). One crucial fact to keep in mind is that there may be co morbid conditions including depression or other mood disorders that can drastically increase the risk of suicide, and must be taken into consideration.

Although there has been little research done with crisis intervention and the patient with BPD, there are several articles that relate to joint crisis plans or psychiatric advance directives for

mental health care in general. One particular study, which included 160 participants with psychotic disorder or bipolar disorder showed a reduction in compulsory admission to the hospital, and overall mental health service utilization (Henderson, et al., 2004; Flood, et al., 2006). This joint crisis plan was formed between the treatment team, including the psychiatrist, care coordinator, and project worker, and the patient and is used to direct care during times of crisis. It is held by the patient, which is intended to empower them, and contains the information they choose to share about their condition (Henderson, et al., 2004). Although the results of this study look promising, there is one limitation to the study that only 38 percent of the eligible patients who were recruited chose to participate, which limits the ability to generalize the results (Henderson, et al. 2004). When looking at the cost effectiveness of this intervention it is has been shown that this could be a very cost effective way to decrease readmission to the hospital, as well as decreasing the resources being utilized (Flood, et al., 2006). The main limitation of this study is that the patient's opinions regarding the effectiveness of the intervention was not polled after the study, but it sensible to presume that a decrease in hospital stays would improve one's quality of life (Flood, et al., 2006).

Likely as a result of the previous studies relating to joint crisis plans, Moran, et al. (2010) is proposing a randomized controlled trial be conducted specifically related to borderline personality disorder. This outline for care during crisis has been proven effective for patients with psychotic disorders and bipolar disorders, and therefore shows promise for BPD (Henderson, et al., 2004; Flood, et al., 2006). The proposed study will recruit 120 participants and divide them into two groups: the joint crisis plan group and the treatment as usual group. The outcomes that will be measured are related to self-harm behaviors and engagement with mental

health services (Moran et al., 2010). This study will provide greater insight into the effectiveness of joint crisis plans for patients with borderline personality disorder.

Henderson, Swanson, Szmukler, Thornicroft, and Zinkler (2008) have done extensive research regarding the different types of psychiatric advance directives and joint crisis plans. They have found that these exist all over the world including in the United States and many countries in Europe. Their position on these advance directives is that although they are useful in aiding providers in decision making regarding crisis intervention, more research needs to be done in order to examine the outcomes of such intervention. They believe that such a plan could reduce the possible conflict between the treatment provider and the patient in times where the patient presents in crisis and is unable to utilize healthy coping mechanisms. The two main challenges of implementing a plan such as this would be disseminating the advance directives to providers in the community where the patient would present in times of crisis, and following through with the plan. There is an option to make this a legally binding contract, but that also comes with complications due to the nature of each individual crisis and the fact that ultimately the patient still has the right to make decisions regarding their treatment if they are competent to do so (Henderson et al., 2008).

One study that has been done that is specifically related to crisis intervention reveals promising results that indicate crisis intervention, instead of treatment as usual, can help to decrease rates of self-harm and readmission to the hospital, therefore decreasing costs associated with treatment. In this case, the crisis intervention strategies included brief hospitalization that was five days or less, intensive psychotherapy and interdisciplinary care, and was for voluntary as well as non-voluntary patients. The results of this study indicate that short-term intensive services in an inpatient psychiatric facility are most effective in managing patients with BPD

when the appropriate specialized outpatient programs are assigned to the patient, but that more research is indicated in order to make definitive conclusions (Berrino et al., 2010).

Hospitalization

There are varying opinions on whether or not inpatient hospitalization is effective in treating patients with BPD, especially when they have engaged in self harm behaviors, have suicidal ideation, or have made attempts at suicide. Goodman, Roiff, Oakes, and Paris's (2012) review of the current literature outlines both views of this issue. On one hand you have the American Psychiatric Association (APA) Guidelines on Suicidal Behavior which provide liberal indications for inpatient hospitalization for patients with suicidal ideation or behavior. Although this is not specific to BPD, it would apply to all with this presentation. The APA Guidelines for the Treatment of BPD follows along similar lines for hospitalization, but also adds in indications for pharmaceutical treatment, neither of which has evidence showing a clear benefit. On the other hand, there are also those opposed to hospitalization, such as Paris (2004), whose opinion is based on the lack of empirical evidence showing the effectiveness of inpatient hospitalization for suicidal patients with BPD.

Goodman et al. (2012) lays out clear recommendations regarding the management of the suicidal patient with BPD including: following the APA guidelines; paying attention to co-morbid conditions such as substance abuse and mood disorders and to treat those as indicated with medications and other psychotherapeutic interventions; establish strong outpatient care therapeutic alliance with frequent suicide assessments and family support; when hospitalization is deemed necessary to make it as brief as possible, but always consider the alternatives of a crisis unit or partial hospitalization program; clearly document the decision making by the

provider; and the recognition that about 50% of providers will lose a patient to suicide throughout their career and that providers should seek support if this occurs.

There is no doubt that hospitalization of the patient with BPD may at times be necessary, but there is evidence that hospitalizations should be kept as brief as possible to prevent positive reinforcement of negative behaviors (Paris, 2004; Oldham, 2006; Silk et al. 1994). The times when hospitalization of the BPD patient is necessary could include when presenting with psychosis, major depression, or bipolar symptoms (Oldham, 2006). Resistance to consideration of inpatient hospitalization by health care providers stems from the belief that this may in fact exacerbate behavioral regression, staff splitting, disruptive behavior, as well as ignoring the real problem at hand that is taking place in their life (Borschman & Moran, 2011; Paris, 2004). While in the hospital, patients are able to put real life issues on hold and much of the time are not hospitalized long enough to make much progress in psychotherapy as it takes a strong therapeutic relationship from the provider that is much more attainable in outpatient therapy. Paris (2004) also comments that "suicidal precautions used in hospital setting reinforce the very behavior one is treating. The more suicidal precautions one introduces, the more the patients tend to regress" (p. 242). Patients get more attention from staff when participating in negative behaviors such as self harm or suicidal thoughts, than those who are working hard at learning coping skills and showing improvement.

Cognitive behavioral therapy and dialectal behavioral therapy

With the research that has been gathered it is evident that there are some great benefits achieved with the use behavior therapies as an intervention for patients with borderline personality disorders. Behavioral therapies are not interventions that can be completed during an acute crisis, but are long term strategies that can help to prevent crisis. It is important for

providers to be aware of the different types of psychotherapies available to patients as they can suggest the implementation of the strategies they have learned during times of crisis. Two studies (Linehan et al, 2006; Davidson et al, 2006) have shown that there was a significant reduction in suicidal acts, inpatient psychiatric hospitalizations, and an overall improvement in quality of life for the patients for the group assigned to behavior therapies as compared to the treatment as usual or general psychiatric management groups. Interestingly, Linehan et al (2006), showed the most promising results with an almost 50 percent reduction in suicide attempts between the dialectal behavioral therapy (DBT) group and the control group. Kliem et al (2010) did a meta-analysis on this topic and agrees that DBT has been found to be the most effective when evaluated suicidal behavior and self-injurious behavior in BPD patients.

The overall theme of all the studies and related to crisis management for borderline personality disorder is that more research is needed in this area. There are promising results out there, but nothing is yet definitive because of the lack of research studies specific to BPD. Currently, it is unclear whether or not hospitalization in an acute psychiatric facility results in a decrease in suicidal or self-harm behavior, and whether it is a cost effective strategy. There is also evidence lacking to support specific interventions that could be used in a crisis management plan. One thing that is clear is that intensive outpatient treatment with psychotherapy is the key when lasting behavior and life changes are sought with patients with BPD.

Methods

A literature search and review has been conducted to gain background information, and to find supporting evidence for the need for crisis management strategies. A search of databases was conducted using the University of North Dakota's Harley French Library website. Based on the topic the databases searched were CINAHL, PubMed the Cochrane Library and PsychINFO.

In the CINAHL database, CINAHL headings were used to search *borderline personality disorder*, as well as several terms relating to crisis intervention such as *crisis intervention* and *crisis management* were searched and resulted in four citations, limits were then placed of English and dates of 2006-2012 resulting in two citations. The PubMed database was searched using the MeSH terms *borderline personality disorder* AND *crisis intervention*. This search resulted in 38 citations. The limit of English decreased the amount of citations to 25, and a further limit of past ten years resulted in seven citations. The Cochrane Library was searched with the keywords *borderline personality disorder* and *crisis intervention* and resulted in 25 Cochrane reviews, and five controlled trials. The search was then limited to the years 2005 to 2012 which produced two reviews, and five trials. Two of the reviews and one of the trials were appropriate for this literature review. A search using the PsychINFO database was performed using the keywords *borderline personality disorder* AND *crisis intervention.* This search resulted in 57 citations, so limitations of English and linked full text were placed which reduced the results to 11 citations. The same method was used for the keywords *borderline personality disorder* AND *crisis management*. This produced five citations. Finally, three additional articles were obtained using the resource lists from the 19 pertinent articles retrieved using the above methods. Although there were many resources found regarding the topic of borderline personality disorder, there is a great need for further research and studies that are strictly related to crisis management.

The information gathered throughout this process has been disseminated to a select group of staff at an inpatient behavioral health unit. The multidisciplinary staff selected included a psychiatrist that works with adults, a social worker, the assistant director of the unit, and 4 registered nurses who work primarily with the adult patients. Those attending the presentation

were given a handout with the major points bulleted for future reference (see Appendix). At the end of the presentation time was allotted for questions as well as recommendations and discussion regarding how the unit could benefit from a crisis management plan and if it would or wouldn't be appropriate and/or beneficial to the unit.

Results

After the information was presented (see Appendix), those attending were asked to provide their thoughts and opinions of the information. The participants all expressed interest in the topic and felt the information about borderline personality disorder and the concepts presented were relevant to the unit. Each participant shared a story or two about their interactions with patients with borderline personality disorder. Some of the stories involved feelings of frustration and feeling they were being manipulated in some way, but there were also some feelings of helplessness. One of the nurses shared her thoughts on the need for more resources and interest in participating further research on the topic. The consensus from the group was that currently the unit does not have the resources to implement a complete crisis management plan, but that further staff education on the topic could be helpful in the day to day management of patients with BPD. Based on the feedback from the participants, a crisis management plan will not be implemented at this time due to lack of supporting evidence, but continued literature review will be done and considered in the future.

Discussion

Borderline personality disorder is a pervasive problem in mental health. The effects of maladaptive coping, impulsivity, instability of interpersonal relationships, and mood lability plague patients with this disorder and often times results in presentation to health care providers while in crisis. Patients with BPD often participate in unhealthy activities during times of crisis,

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mainly self-harm and suicidal behavior. Management of these crises can be problematic and stressful for providers if an intervention plan is not in place, which in many cases it is not.

Although there is a lack in evidence to make specific recommendations, it is clear that there are strategies for effective crisis management. One strategy is the construction and implementation of a joint crisis plan between the patient and the provider. This document can outline the patient's preferences in management during times when they are experiencing a crisis. Other information that would be helpful in this document is to have the patient identify what a crisis looks like for them, what are some of the events that precipitate a crisis, and some the coping skills they have found to be effective in the past. A significant limitation to this is the dissemination of this document to health care providers and crisis management specialists that the patient may come in contact during a crisis, but this could be accomplished if the possibilities for contact could be identified and collaboration could take place with them before a crisis occurs.

Outpatient providers generally have contact with patients with BPD more than inpatient providers and therefore they also have a significant role in crisis management. Evidence shows that behavioral therapies have been effective in the management of this disorder and help to give patients the skills needed to handle crises when they arise. This would also be an appropriate setting to compose the joint crisis plan. Outpatient providers, therapists specifically, often form a longer term relationship with the patient that promotes trust and mutual respect on a therapeutic level and this should be utilized when discussing how to intervene in times of crisis.

Another consideration that must be made when discussing crisis management is the option of inpatient hospitalization. The facts are not clear regarding the effectiveness of this intervention in the treatment of borderline personality disorder during periods of crises. The

decision of hospitalizing a patient needs to be considered, especially if assessment shows that the patient is at significant risk of self-harm or suicide. Safety of the patient needs to be the most important concern for the provider during this time. Once hospitalized, it is up to the inpatient unit to manage the crisis at hand. Recommendations during hospitalization include: making the stay as brief as reasonably possible, making a contract with the patient that discusses the discharge plans and what is expected of them during hospitalization, and setting up comprehensive outpatient care that the providers and the patient agree on. By laying out the expectations up front, there is less room for misunderstandings and conflict that can result in poor outcomes for the patient.

Implications for Nursing

Nurses play a significant role in the care of patients with borderline personality disorder. In the inpatient unit, the nurses are generally around the patients more than other health care providers and perform routine assessments of patient's behaviors, moods, and risk for self-harm. Nurses truly are the front line of the unit and can make a big impact on how the hospitalization will go for the patient and the staff involved. These assessments and interactions should be done with careful regard to patients and their feelings. One should not be judgmental or biased in any way, but be empathetic, caring, and make an attempt to form a trusting therapeutic relationship with the patient. Nursing education regarding patients with borderline personality disorder should reflect the need for compassionate care, but also discuss what a crisis looks like for these patients and outline ways to help patients during these difficult times. Some of the topics that should be discussed are limit setting, use of community resources, exploration of feelings that lead to the crisis, and effective and healthy coping strategies.

Research regarding this topic is another area where nursing can and should be involved. Further research on crisis management for patients with BPD could be done on a basic level in any hospital or community health care facility that has patients who present in crisis. Nursing could be involved in assessments and implementation of crisis interventions which could then be evaluated for effectiveness in several outcome areas such as patient self-harming behaviors, cost and use of resources, and improvement of quality of life. Implementation of crisis management plans will not become widespread until more evidence is gained regarding positive outcomes.

One important area to be mindful of in health care is health care policies and laws. They are often what direct the care of the patient and they play a large role in mental health. Providers that are involved with the care of a patient with BPD are very aware of the implications that a suicide could have on them and their facility, and therefore are often times overly cautious and quick to hospitalize patients presenting with self-harm or suicidal behaviors. There is currently a lack of evidence showing that hospitalization is effective in decreasing the risk of suicide for these patients, but the fear of litigation often drives their decision. Providers need to be aware of the fact that almost fifty percent of providers will lose a patient to suicide during their career and that many times, there is nothing that could have changed the outcome. Documentation of the assessment and follow-up plan is crucial in protecting oneself from the threat of being sued. A crisis management plan that involves a joint crisis plan that the patient has composed with the help of a multidisciplinary team could help in this situation. The main question regarding these plans is whether or not it should be legally binding. It could be helpful for health care policy makers to explore the usefulness of joint crisis plans and make formal recommendations regarding their application.

Conclusions

Crisis management for patients with borderline personality disorder is a topic that seems to be getting more attention in the mental health arena, but there continues to be an extreme lack of evidence and research being done specifically regarding this issue. The potential benefits that can be gained from effective crisis management would have a significant impact for patients and providers alike. Possible outcomes could include: a decrease is self-harm behaviors, decrease in suicide attempts and completions, a reduction in utilization of expensive resources, improved quality of life for patients, and providers that are confident that they have managed the situation appropriately. The inpatient unit that participated in this project will not be implementing a crisis management plan at this time, but several staff members indicated they are interested in conducting further literature reviews to gather the evidence needed to show clear benefits of the interventions involved.

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