Issues in Mental Health Nursing, 26:507–517, 2005
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ISSN: 0161-2840 print / 1096-4673 online
DOI: 10.1080/01612840590931957

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CLINICAL SUPERVISION OF NURSES WORKING WITH PATIENTS WITH BORDERLINE PERSONALITY DISORDER

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Some nurses describe individuals diagnosed with borderline personality disorder (BPD) as among the most challenging and difficult patients encountered in their practice. As a result, the argument has been made for nursing staff to receive clinical supervision to enhance therapeutic effectiveness and treatment outcomes for individuals with BPD. Formal clinical supervision can focus on the stresses of working in a demanding environment within the work place and enable nurses to accept accountability for their own practice and development (Pesut & Herman, 1999). A psychiatric-mental health clinical nurse specialist can provide individual and/or group supervision for the nursing staff, including education about patient dynamics, staff responses, and treatment team decisions. A clinical nurse specialist also can provide emotional support to nursing staff, which enhances job satisfaction, as they struggle to maintain professional therapeutic behavior with these individuals.

The prevalence of borderline personality disorder (BPD) is estimated to be about 10% of individuals seen in outpatient mental health clinics and 20% of psychiatric inpatients (American Psychiatric Association

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[APA], 2000). Nurses describe individuals diagnosed with BPD as among the most challenging patients encountered in their practice (Bland, 2003; Cleary, Siegfried, & Walter, 2002; Fraser & Gallop, 1993; Greene & Ugarriza, 1995; Pavlovich-Danis, 2004). In a study of nurses who cared for patients with BPD, findings indicated that this patient population was difficult to manage and treat, and that nurses perceived a need for further education and training to aid in working with these individuals. Additionally, most staff (84%) found this patient group to be more difficult to work with than other patient groups (Cleary et al., 2002). Some of the most difficult and challenging behaviors reported in the literature are unstable interpersonal relationships, unstable moods, manipulation, splitting, transference, and countertransference (Gallop, 1985; Greene & Ugarriza, 1995; Piccinino, 1990).

Perhaps as a result of working with patients who can present with challenging and difficult behaviors, mental health nurses and community mental health nurses have the highest reported level of stress (Rees & Smith, 1991), and a correlation between ethical distress and burnout in nurses is evident in the literature (Severinsson & Hummelvoll, 2001; Sundin-Huard & Fahy, 1999). A number of authors have pointed out that lack of supportive resources (e.g., collegial clinical supervision, managerial support) in nursing increases the level of stress and burnout (Cutcliffe & Burns, 1998; Edwards, Burnard, Coyle, Fothergill, & Hannigan, 2000; Melchior, Bours, Schmitz, & Wittich, 1997). Clinical supervision that includes attention to the emotional needs of the supervisee has been linked with increasing the quality of patient care and job satisfaction by decreasing ethical distress and burnout in mental health nurses (Cameron, 1997; Cutcliffe & Epling, 1997; Robertson, Gilloran, Mckee, Mckinley, & Wight, 1995). Accordingly, this paper describes some of the challenging behaviors of patients with BPD and reiterates the need for nurses who work with this client group to receive clinical supervision. Particular attention is given to the range of benefits that arise from engaging in clinical supervision.

CHALLENGING BEHAVIORS OF PATIENTS WITH BPD

In the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV, 4th ed., text rev., APA, 2000, p. 710), BPD is described as “a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts.” BPD manifests in severe problems in sustaining close interpersonal relationships, with dramatic shifts from idealization to devaluation; self-destructive behaviors associated with

impulsiveness, including sexual promiscuity, self-mutilation, and suicide attempts; intense volatile feelings and moods; and identity disturbance. Patients' thinking can be grandiose, with distorted versions of reality; and communications of these patients can be vague, tangential, and over personalized (APA, 2000; Bland, 2003; Sable, 1997).

Individuals with borderline personality disorder have interpersonal relationships characterized by instability, intense feeling, and crises. They have difficulty being alone and may frantically try to avoid real or imagined abandonment by hanging on to a relationship, even after having alienated the other person. As a result of this behavior, nurses often struggle with balancing the needs and demands of the patient with BPD with the other patients' needs on the unit. Additionally, the panic state experienced by the patient with BPD frequently results in impulsive, self-destructive behavior and suicide attempts that culminate in and continue during hospitalization (Bland, 2003; Piccinino, 1990).

Self-destructive behaviors may be efforts at self-regulation of intense emotions that interfere with cognitive functioning and effective problem solving (Linehan, 1993; Shearin & Linehan, 1994; Wagner & Linehan, 1999). Self-destructive behaviors contribute to problems in human relations, complicate the therapeutic task, and are related to low treatment success. As a result, nurses interacting with patients with BPD have expressed feeling emotionally and physically drained and frustrated (Cleary et al., 2002).

Many of the behavioral problems associated with BPD have been linked to problems with emotion processing (Bland, 2003; Levine, Marziali, & Hood, 1997; Stein, 1996). When intense affects are not processed adequately, unstable moods frequently occur. Impulsive behavior such as lack of control of inappropriate, intense anger leads to displays of anger or physical fights. When the patient with BPD displays intense anger, nurses may feel personally attacked, angry, helpless, frustrated, or fearful for their safety and the safety of the other patients. Nurses may see the patient's behavior as deliberate and bad rather than part of the illness. As a result, nurses may become less empathetic, withdraw, and become affectively distant from the patient (Fraser & Gallop, 1993; Gallop, Lancee, & Garfinkel, 1989).

Nurses frequently view patients with BPD as being healthier than other patients because they initially present themselves with more "normal" behavior (DeLaune, 2004). Therefore, when they exhibit behaviors described as clingy, controlling, demanding, or manipulative, the nurses believe they have been tricked by these patients, and may feel angry, frustrated, and a failure. As a result, the patients are often seen as deliberately trying *not* to improve or as sabotaging their treatment, which contributes

to the nurses' sense of frustration and failure (Frazer & Gallop, 1993; Greene & Ugarriza, 1995; O'Brien, 1998).

In addition to manipulative behavior, patients with BPD tend to defend against conflicts by splitting people into good and bad objects. This defense is due to their difficulty with integrating all characteristics of the person, allowing them to sustain ambivalent relationships (Gunderson, 1984; Kernberg, 1975). This inability to synthesize contradictory good and bad self or other representations, has been called "splitting" (Gunderson, 1984; Piccinino, 1990). The patient with BPD projects intense feelings and previously internalized good or bad self and object representations onto the nursing staff, a process called projective identification (Horsfall, 1999). Thus, these patients selectively divide or split the nurses into good or bad persons. The conflicts and splitting of the nursing staff can carry over to the treatment team, and polarization of staff can occur, particularly as transference and countertransference reactions evolve. If the conflicts, splitting of staff, and polarization of the treatment team are not reconciled, the patient diagnosed with BPD may be precipitously discharged from treatment and future treatment team relationships impaired, thus rendering ineffective future patient treatment (Cleary et al., 2002; Fraser & Gallop, 1993).

Transference occurs when the patient with BPD experiences an emotional reaction toward a current person with unconscious drives and feelings that originated with earlier parental caretakers. Original relationships are reconstructed with nurses, and intense feelings of love, hate, anger, fear and so forth, are experienced again. This re-enactment of strong emotional conflicts within the parental relationship is transferred to the relationship with nursing staff and can evoke the same intense countertransference reactions from them, due to their own developmental experiences. The conflicts arise as nurses act out the internal good or bad dynamics of the patient with BPD (Greene & Ugarriza, 1995). Countertransference reactions by nurses affect the patient's treatment because a therapeutic relationship no longer exists.

CLINICAL SUPERVISION OF NURSES

It is often stated that the core element of psychiatric nursing is the relationship between the nurse and patient; a relationship personified by respect for the client, facilitating trust, and actively engaging the client in his or her care (O'Brien, 1998; Severinsson & Hummelvoll, 2001). Drawing on the seminal work of Peplau (1952), many authors have suggested that the development of a therapeutic relationship is essential before the nurse can engage in a working phase with any patient,

particularly a patient diagnosed with BPD (Fraser & Gallop, 1993). The difficult and challenging behaviors of patients with BPD may result in negative consequences for both nurses and patients (O'Brien, 1998; Piccinino, 1990). These negative consequences, however, could be minimized or alleviated by clinical supervision.

Clinical supervision of nurses has been recommended in the psychiatric nursing literature for some time, and is seen as particularly necessary for nurses who work with patients diagnosed with BPD, (Bonnivier, 1992; Cleary et al., 2002; Gallop, 1985; Kaplan, 1986; Schroder, 1985). The American Psychiatric Association (2002) recommends both psychiatric therapies for patients diagnosed with BPD and clinical supervision of staff working with these patients. However, ongoing clinical supervision has not been implemented for nursing staff in most psychiatric treatment facilities, even though it has been recommended in the past (O'Brien, 1998).

Clinical supervision has been described as an intensive, interpersonally focused, one-to-one or group relationship in which the supervisor (sometimes a psychiatric clinical nurse specialist, CNS) facilitates therapeutic competence in the other persons (Bonnivier, 1992; Loganbill, Hardy, & Delworth, 1982). The CNS, who has advanced education and practice in psychiatric pathology, treatment, and communication, can provide staff nurses with knowledge and emotional support while also overseeing and being responsible for the quality of their work. Thus, the CNS enables the nurses to learn, develop, and reflect on practice problems and gain insight, support, and guidance to enhance care and professional development (Pesut & Herman, 1999; Pesut & Williams, 1990). Most nurses working with patients with BPD would welcome clinical supervision. In one study of patients with BPD, 95% of staff recognized the need for ongoing education and clinical supervision and were willing to spend one or more hours per month on education and training (Cleary et al., 2002).

EDUCATION

Some theoretical models of clinical supervision indicate that it can include education of the nursing staff about patient dynamics, staff responses, and the effect of these on treatment team decisions. For example, nurses may not understand why a patient with BPD continues to commit self-destructive behaviors, self-mutilation, and suicidal acts that precipitate frequent hospital admissions. The nurses may feel angry, helpless, disgusted, betrayed, and dismayed at the patient's repetition of such behaviors (Gallop, 2002). An understanding of the absence

of affect or the internal affect experienced by these patients and their inability to regulate these emotions, the frequency of occurrence of self-destructive behaviors, and patients' inability to comfort themselves can have a significant impact on practice. Knowledge and a deeper understanding can help nurses shift their view of the patient as deliberately bad, manipulative, and attention-seeking to a perception of the patient as one who is struggling with adaptively expressing intense, negative emotions (Bland, 2003; Gallop, 2002). Thus, educational programs can focus on etiology, patient behavior, nursing staff responses, and treatment to improve nurses' knowledge of and attitudes toward the patient with BPD (Bland, 2003; Miller & Davenport, 1996).

Clinical supervision by a psychiatric CNS can enable nurses to become more aware of their own feelings and responses to the patient with BPD (APA, 2002; Cleary et al., 2002; Gallop, 1985). Countertransference reactions to this patient group are likely to exist outside of the nurses' consciousness; accordingly, clinical supervision can enable nursing staff to become more aware of their reactions and behavior (Cutcliffe & Burns, 1998; Smith, 2000). For example, clinical supervision can help nurses recognize the dynamics that lead to the splitting of nursing staff into "good" and "bad" nurses, the conflicts that arise between nurses and the patient, and the conflicts that arise among nurses and other treatment team members as a result of patient acting-out. This knowledge can help nurses make sense of these behaviors, engender confidence, reduce their own defensive behaviors, and perhaps reduce the number of destructive re-enactments that take place (Wilkins & Warner, 2001). Understanding their countertransference reactions, particularly negative ones, can help nurses engage in a therapeutic working relationship with the patient diagnosed with BPD (Frazer & Gallop, 1993). Thus, clinical supervision can aid the nursing staff in maintaining professional behavior, a therapeutic relationship with the patient, and a therapeutic environment.

Clinical supervision can include discussions of how trying to stop self-destructive behaviors can derail treatment efforts. For example, nurses can become involved in power struggles when trying to protect the patient from self-destructive and self-mutilating behaviors. These power struggles can lead to punitive consequences for the patient such as forced seclusion, forced restraint, forced medications, and other oppressive measures. No self-harm contracts, when violated by the patient with BPD, can lead to precipitous discharges from the hospital and termination of therapy. Refusing to work with or treat the patient because of these self-harm behaviors can lead to more serious self-harm or suicide (Gallop, 2002). The CNS can educate nurses about this dynamic and

assist them in finding ways to tolerate the patient's intense affect and self-destructive behaviors, identifying stimuli that trigger intense affect and self-destructive behaviors, and helping patients use more effective coping strategies (Bland, 2003; Gallop, 2002; Stuart, 2001). With clinical supervision, nurses can begin to understand their role in these power struggles and realistically appraise the limits of their ability to prevent self-destructive behavior and suicide.

EMOTIONAL SUPPORT

There is a well-established and not insubstantial extant literature that demonstrates how nurses need emotional support (see Gilmore, 2000, for a recent review). Given the challenging nature of some patients with BPD, it is not surprising that nurses need to pay particular attention to their emotional well-being within their clinical supervision. Looking at one's own behavior is not easy and it can be threatening to nursing staff, particularly if they are concerned about being analyzed or think disciplinary actions might be taken against them for their behavior. To allay these concerns, nurses need emotional support within individual and/or group clinical supervision, without the threat of administrative disciplinary actions (Bonnivier, 1992; Cutcliffe, Epling, Cassedy, McGregor, Plant, & Butterworth, 1998a, 1998b).

Emotional support can be obtained through clinical supervision that provides both formal and informal systems for nurses to explore, discover, and examine their practice in a safe and supportive environment. Individual clinical supervision by the CNS can be helpful to nurses who are struggling with values or ethical conflicts pertaining to these intense emotions and maladaptive patient behaviors such as self-mutilation and suicidal gestures. For example, nurses may feel victimized in a system that explicitly or implicitly maintains that absolute patient safety is a possibility. This expectation of absolute safety places undue responsibility on nurses to ensure that patients with BPD do not harm themselves, even when these patients are intent on doing so (O'Brien, 1998). Individual clinical supervision can provide education and clarification of system and personal values and conflicts related to this expectation, case review, and empathic debriefing for a nurse whose patient with BPD just cut his or her wrist during the nurse's assigned work shift.

This process of emotional support may increase quality of patient care and job satisfaction, as well as reduce staff turnover by decreasing ethical distress and burnout (Cameron, 1997; Robertson et al., 1995). Emotional support can be provided to nurses through both informal and formal systems of group clinical supervision. For example, a formal

system approach would be when the CNS schedules weekly or bi-weekly brown bag group lunch meetings for staff nurses to reflect upon their feelings and current problems interacting with patients with BPD. The clinical supervisor can empathically process these difficult interactions and problems, validate nurses' feelings and perceptions, and provide current clinical resource information. An example of an informal system approach to clinical supervision is when the CNS provides immediate emotional support to an individual and/or a group of nurses when emergencies arise, such as a patient losing control and verbally attacking staff. These non-threatening approaches may enable nurses to provide emotional support to each other both inside and outside of the group.

Formal clinical supervision of nurses can be done at a scheduled time in a scheduled location such as a group conference room, using the processes previously described. This supervision may cause other issues of concern to arise such as single discipline or multidiscipline sessions and voluntary or mandatory attendance (Richardson, Tate, Leonard, & Patterson, 2003). Single discipline or clinical supervision of nurses by the CNS is recommended by these authors, as nurses working with patients with BPD for long periods of time may feel betrayed by nursing administrators, psychiatrists, and allied health professionals who fail to recognize the reality of nursing the patient. These colleagues spend less time with the patient, are viewed by the patient as rescuers, and may fail to understand the plight of the nurses, thus leaving the nurses feeling victimized, helpless, angry, misunderstood, and ineffective in their interventions with the patient (O'Brien, 1998). Voluntary attendance is recommended as the nurses may feel further victimized if they are forced to attend formal clinical supervision sessions against their will. However, positive incentives by nursing administrators and managers could be given to nurses to encourage attendance at formal and informal clinical supervision sessions as a way of showing support to their staff.

CONCLUSION

Although clinical supervision of nurses has been recommended in the psychiatric nursing literature (Bonnivier, 1992; Cutcliffe & Burns, 1998; Cutcliffe & Proctor, 1998; Gallop, 1985; Kaplan, 1986; Schroder, 1985) within North America, few clinical settings provide nurses with ongoing clinical supervision. The benefits of ongoing clinical supervision for nurses working with patients with BPD have been enumerated. Clinical supervision can provide validation, insight, and system support for nurses working with patients with BPD (Laskowski, 2001). Within clinical supervision, nurses can explore new therapeutic techniques,

attitudes, ethics clarification, and system supports that can be useful, particularly during difficult times in a therapeutic relationship. Without clinical supervision of nurses to insure a therapeutic environment, patients may experience ineffective treatment and frequent readmissions, while nurses may experience stress and burnout.

Formal and informal systems of clinical supervision can contain the stresses of working in a demanding environment within the work place and enable nurses to accept accountability for their own practice and development (Pesut & Herman, 1999). The benefits of ongoing clinical supervision include improved patient care, enhanced effectiveness of the treatment team, and better management of these difficult and challenging patient behaviors.

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