PERSONALITY DISORDERS AND EFFECTIVE TREATMENT

To the Editor:

Most nurses do not think that working in a psychiatric inpatient unit is something they would like to do or a place where they can make a difference. However, more nurses are needed in these settings to identify different personality disorders and helpful therapies.

The two most common personality disorders, according to the Diagnostic and Statistical Manual of Mental Disorders, are antisocial personality disorder (ASPD) and borderline personality disorder (BPD) (Ritter & Platt, 2016). Incidence of ASPD in forensic samples “is estimated to be as high as 70%” (Ritter & Platt, 2016, p. 39). ASPD is commonly associated with BPD, substance abuse, and high suicide risk (Ritter & Platt, 2016), and is characterized by a pattern of having no regard for and violation of someone else’s rights. Individuals with ASPD may also “demonstrate deception, criminality, lack of remorse, and a sense of entitlement” (Ritter & Platt, 2016, p. 39). Individuals with ASPD may try to manipulate others for their own gain; many use suicidal threats as a way to get what they want.

BPD accounts for 20% to 40% of disorders found in patients in inpatient units (Ritter & Platt, 2016). Individuals with BPD tend to rely on splitting (a defense mechanism in which the individual mentally separates the good and bad) and also have a tendency to self-harm. Self-harming behaviors include cutting, burning, and scratching. Patients with these behaviors are watched more carefully. Ritter and Platt (2016) explain that “the hallmark of BPD is avoidance of abandonment, either real or imagined. Patients with BPD may lie to gain admiration or nurturance from staff and often engage in power struggles” (p. 39).

Disruptive behaviors are common in individuals with ASPD and BPD. Manipulative behavior is used by those who need to feel like they have power. Some manipulative behaviors include “deception, angry verbalizations or actions, disruption of the treatment plan, covert aggression, devaluation, intimidation, demands, ultimatums, compliments, clingingness, exaggeration, and secretiveness” (Ritter & Platt, 2016, p. 40). Many different types of treatment exist to help with these behaviors.

Dialectical behavior therapy (DBT) is a type of cognitive-behavioral therapy (CBT) that helps decrease suicidal behavior in individuals with BPD, in which “treatment is focused on emotion regulation, interpersonal effectiveness, distress tolerance, and mindfulness” (Ritter & Platt, p. 41). Some studies have shown that current treatments for BPD help with life-threatening behaviors and psychiatric symptoms, but not with social functioning and relationships. Treatments for ASPD help with substance abuse, but not with antisocial behavior. I had never heard of DBT and CBT until my counselor told me about them. Ritter and Platt’s (2016) article explains them well—especially how effective they are.

With all of these behaviors and treatments, it can be challenging to help individuals with ASPD or BPD. Currently, no single treatment is effective. However, symptoms of disorders can be managed. Involving a counselor, family member, or close friend can make all the difference in patients’ lives. Ritter and Platt’s (2016) article highlights how far we have come in researching and discovering the best treatment for different disorders.

My interest in this topic is due to my counselor believing that I have BPD in addition to having depression and anxiety. Although I am not yet clinically diagnosed, I believe my counselor is right. I show the traits of BPD and am reaching out to a specialist for better counseling. Ritter and Platt’s (2016) article made me realize that I am not alone and that BPD may not be treatable by medicines, but there is hope for me to receive better counseling, which will help me focus on my problem areas.

REFERENCE


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