Towards understanding some complex borderline behaviours

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This article aims to explore and explain some possible antecedents to behaviours revealed by consumers in mental health settings who evoke strong and often negative responses in nurses and other health professionals. The contemporary exemplar *par excellence* is people who are diagnozed as having a borderline personality disorder. The paper discusses four different but overlapping domains that may contribute to understanding the difficulties many nurses face in relation to working with consumers whose behaviours are complex and distressing. Firstly, these begin with a brief discussion of psychiatric labelling and stereotyping associated with borderline personality disorder. Secondly, the connections between trauma in childhood and psychiatric vulnerability are explored, as nurses and other health professionals sometimes do not appreciate the debilitating and long-term consequences of the survival of childhood abuse or sexual assault. Thirdly, some unconscious defence mechanisms are outlined to partly explain behavioural interactions often displayed by people with a diagnosis of borderline personality disorder. Finally, behavioural concomitants of projection, splitting and projective identification are discussed: they include identity diffusion, self-mutilation and suicide attempts. All of these topics are explored to encourage nurses to support consumers to express pain in more constructive ways.

Keywords: borderline personality disorder, identity diffusion, labelling, psychiatric sequelae of child abuse, self-mutilation, unconscious defence mechanisms

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Introduction

This paper aims to look underneath the descriptive level of some behaviours that are associated with people with a borderline personality disorder diagnosis. The intention is to increase understandings of complex consumer behaviours and enhance mental health nursing practice.

The issue of psychiatric labelling is introduced to show that certain psychiatric diagnoses, along with other terms frequently used in clinical settings, are viewed negatively by some clients and may impede the development of a therapeutic relationship. Survival of child abuse is then explored in relation to unconscious defence mechanisms that commonly emerge in response to the experience of severe emotional trauma. The concepts of labelling and trauma survival are discussed with a view to beginning to explain some client behaviours and nurses' responses to these behaviours. Against this background, client experiences such as self diffusion and self-harm behaviours are explored from consumer perspectives.

Psychiatric diagnoses, labelling and stereotyping

Psychiatric diagnoses and clinical terminology are used by health professionals to develop common understandings of certain symptom clusters and likely treatment modalities. Mental health professionals become accustomed to using medical and clinical jargon on a daily basis. These are essential for health professionals, but do not necessarily facilitate the understanding of a specific client's experiences

or fears. This section of the paper argues that commonplace psychiatric diagnoses can easily be experienced and understood negatively by consumers.

Rosenhan's now classic 1970s research (Rosenhan 1996) involved pseudo-patients gaining admission to a dozen psychiatric hospitals across the USA. All of the participants had difficulty convincing the psychiatrists that they were well and should be discharged. This took between 17 and 52 days to achieve.

> 'Once a person is designated abnormal, all of his [sic] other behaviors and characteristics are colored by that label' (p. 75).

The pseudo-patients were recognized as such by real patients, but apparently not by nurses or doctors. In other words, negative labelling tends to stick to the labelled person, even in the face of contrary evidence.

Gallop (1988) explores labelling and stereotyping by nurses in relation to people with a borderline personality disorder diagnosis. Stereotyping is the attribution of characteristics to an individual by virtue of the belief that the person belongs to a specific group. In this instance the group is defined by a psychiatric diagnosis.

The presence of such a diagnosis on an admission form, emphasizing it during handover, or describing a newly admitted person in vivid and dramatic terms can set up negative expectations (Gallop 1988). When the nurses in this study described a client as 'difficult' and 'demanding', they would consider the person to be a 'borderline' client, even if that was not the medical diagnosis (Gallop 1988). Conversely, when a person was diagnozed as having a borderline personality disorder, the nurse respondents assumed that the clients would be 'difficult' and 'demanding' (p. 19). Via this circular logic, clients with that diagnosis, or clients who behaved in certain ways, were likely to be negatively stereotyped.

Other diagnoses that appear to have had similar de-individualizing effects on consumers in recent decades include, 'hysteria', 'involutional melancholia' and 'psychopathy'. Possibly such labels function to reinforce the sense that it is people other than health professionals who are mentally ill in these undesirable and stigmatizing ways. Perhaps the frustration involved in working in difficult circumstances in hospitals and the community is displaced onto certain groups of consumers, rather than targeting actual health care system difficulties.

From a consumer perspective, Wadsworth & Epstein (1996) point out that specific psychiatric diagnoses and other clinical terms, such as 'acting out', 'attention seeking', 'dependent' and 'manipulative' that are often associated with people with a borderline personality disorder, are experienced as negative labels conveying messages of disrespect and powerlessness. Psychiatric diagnoses and other clinical terms may be treated by mental health professionals as innocuous or neutral language, however, some consumers experience the language as accusatory or dismissive. These forms of verbal distancing are not conducive to the development of a trusting and effective therapeutic relationship.

Childhood sexual assault and abuse and psychiatric vulnerability

Negative labelling is one fairly common occurrence within mental health services. Another difficulty for some consumers is that their previous experiences of incest and/or rape are ignored, minimized or not understood as being relevant to their present distress. In this section of the paper some sequelae associated with the survival of childhood abuse or neglect are explored.

It is not known what proportion of people seeking assistance from mental health services have survived traumatic experiences, whether these relate to untimely deaths of significant others, parental violence, wars, rape, natural disasters, torture or living in refugee camps. One such experience is that of childhood sexual assault. To increase nurses' understandings of people with a borderline personality disorder (and other psychiatric diagnoses), it can be useful to heighten awareness of the long-term consequences of childhood sexual assault and emotional abuse (Horsfall 1989).

People with the diagnosis of borderline personality disorder are more likely than other mental heath service users to be survivors of ongoing physical and/or sexual abuse as children (Lego 1996). Female children experience higher rates of sexual assault. It is presently estimated that about 75 per cent of people with a borderline personality disorder are women (O'Brien 1998). In the consumer literature one woman considers that when nurses and doctors

> 'are dismissing PDs' [people with personality disorders] pain they are . . . dismissing the seriousness of women's suffering' (Melbourne Consumer Consultants' Group [MCCG] 1997, p. 39).

Many adult survivors of childhood abuse have an unclear sense of self, because their basic emotional and safety needs were not fully met during some phases of childhood development.

> 'When there has been repeated sexual assault . . . [there can be] severe disruption in the self-system of the individual such as an inability to self soothe, an inability to regulate emotions, a lack of a sense of [self] cohesion.' (Hartman & Burgess 1998, p. 398)

In people who have experienced childhood sexual assault, the confusion of personal boundaries may be easiest to understand. Incest perpetrators seduce and/or

coerce a child to give up some parts of their body to the adult for his/her needs. Hence, an adult survivor may remain unsure about a range of issues related to intimacy and privacy (Long & Smyth 1998).

It is not surprising that ongoing experience of incest would leave the child/adult feeling that they do not exist as a separate person and that their body is the occupied territory of an arbitrary and powerful father, stepfather, older brother, family friend or relative (Long & Smyth 1998). [Research during recent decades has shown that men perpetrate more than 92% of sexual assaults against both female and male children (Parker & Campbell 1995)]. A routine aspect of childhood sexual assault is that the perpetrator endeavours to protect himself by blaming the child and enforcing secrecy by, for example, telling the child that he will harm someone important to the child if she/he tells anybody about the assaults (Long & Smyth 1998). A long-term result of these experiences is that the adults blames themselves for the victimization. Survivors of childhood sexual assault are also likely to feel that they do not own their own body, be confused about adult sexual norms and perceive themselves to be 'damaged goods' (Long & Smyth 1998, p. 131).

Many survivors of childhood sexual assault do not become consumers of mental health services at all. However, clients of hospitals and community mental health teams who are long-term survivors of sexual assault have often not received counselling from specialized sexual assault services and have borne the 'burden of secrecy' since childhood (Long & Smyth 1998, p. 133). Some of these people, because of their suffering and behavioural complexity, eventually receive psychiatric attention for 'borderline' or other psychiatric syndromes (Horsfall 1989).

Registered Nurses (RNs) working in mental health settings therefore need to be sensitively prepared for the possibility that any client may have been sexually abused as a child. Because of their experience of betrayal by adults in positions of authority (at least by parents and/or the perpetrator), assault survivors may find it difficult to feel safe in relationships with health professionals (Long & Smyth 1998).

Therapeutic use of self

The therapeutic use of self allows the nurse to use his/her personality, life experience, imagination and other attributes, to attempt to establish a sense of interpersonal safety with and for the client. A primary aim of the therapeutic use of self is to connect with the consumer in a range of ways, from ordinary conversation, through routine service based tasks (such as form filling), to intense consumer focused explorations and the development of care goals (Graham 1994).

Nursing efforts to develop rapport and trust involve an investment of time (Long & Smyth 1998). The requisite patience, perseverance and repeated contact is frequently valued by consumers (Graham 1994). Having a hopeful attitude, an open mind about client experiences and respectful interactions constitute the foundations of trust development.

Respect for individuals is demonstrated when the nurse commits himself or herself to providing structured, consistent, nonpunitive, therapeutic encounters with the client. (Long & Smyth 1998, p. 133)

In other words, the behaviours of the nurse reveal their qualities of trustworthiness and safety to clients whose insecurities and fears require an interpersonal haven from abuse, disrespect, or isolation (Horsfall 1998).

Empathy stands outside fear-punishment dynamics and encourages the client and nurse to work co-operatively towards increased client self-understanding (Lego 1996). Nurse self-understanding and the capacity to discern meaning in the client's experiences and behaviours complement each other and are central to assisting client self-understanding.

Acknowledging stereotyping as an impediment to connecting with people whose lives are marked by psychic pain and despair is a beginning strategy. To achieve therapeutic aims with highly distressed people, the nurse invariably uses her or his self as a means to show understanding and support the person thorough a crisis.

Unconscious defence mechanisms: emotional survival

Along with self awareness, it is likely that the nurse will need to develop a personal schema, or conceptual model, to increase understandings of particularly distressing client behaviours. Drawing on unconscious defence mechanisms can contribute to the enhancement of a framework for understanding human behaviour.

Childhood abuse (or other trauma) survival offers one way of connecting past experiences with clients' present actions and interactions. The utilisation of unconscious defence mechanism concepts may also contribute to an increased understanding of apparently self-defeating or damaging behaviours. An assumption of this psychodynamic model of human interactions is that it is invariably possible to make sense of human behaviour (Burgess & Clements 1997).

Unconscious defence mechanisms can provide a conceptual bridge from client emotional trauma to overt disruptive behaviours. Ritter (1997, p. 20), for example, considers that 'the psychiatric nurse is a mediator between

internal and external worlds'. To support understandings to facilitate this mediation between the inner and outer worlds of clients, the unconscious defence mechanisms of projection, splitting and projective identification are briefly explored.

Understanding unconscious defence mechanisms may offer nurses in mental health settings opportunities to discern meanings behind certain interaction styles and behaviours. Observing and reflecting on external signs of unconscious dynamics can allow nurses to view the strong feelings evoked by some consumer behaviours in a different light.

Freud and his followers consider that every person has an unconscious life that is not self evident, except, perhaps, through dream remnants or slips of the tongue. These psychodynamic theorists consider that all people draw on unconscious defence mechanisms. In the long term, unconscious defence mechanisms may be viewed as falling along a continuum, from being highly adaptive to those that when over-utilized decrease the individual's contact with external 'reality' (Burgess & Clement 1997).

According to psychodynamic theorists, unconscious defence mechanisms are universal human processes. People cannot choose to repress traumatic events, they just are repressed. Repression is the fundamental mechanism that consigns feelings, memory or conflict to the unconscious domain. Unconscious defence mechanisms are intrinsic human strategies for survival. Survival is not merely a physical imperative, each of us have to survive practically and interpersonally, and this is where these defences step in. Unconscious defence mechanisms, by definition, remove painful material from conscious awareness; but the energy of the repressed feelings continue to strive for external expression (Burgess & Clements 1997).

Unconscious defence mechanisms are laid down in childhood circumstances to protect the child from undue anxiety and to allow the child to survive emotionally. These experiences and their unconscious consequences often have effects that continue into adulthood.

> 'Early childhood abuse triggers the development of (unconscious) defensive behaviors and patterns that can become deeply ingrained personality and characterological traits.' (Hartman & Burgess 1998, p. 400)

When the repressed pain or trauma is intense, then the unconscious defence mechanisms are more likely to be 'primitive' and multiple.

Defence mechanisms such as projection, splitting and projective identification effectively prevent conscious access to powerful and negative feelings and thoughts that would cause overwhelming anxiety. Amongst people with a borderline personality disorder, social interactions arising from projection, splitting and projective identification are often evident. These will be discussed in the next section of the paper.

Inner feelings - outer behaviour: projection, splitting, projective identification

Projection is the attribution of one's own unacceptable (according to family beliefs, religious or behavioural standards) feelings or thoughts to another person. Along with denial and rationalization, projection is an unconscious defence mechanism that effectively enables the person to avoid responsibility for their behaviour (Burgess & Clements 1997). Projection gets the unacceptable emotions or ideas out in the open, but they appear to belong to someone other than the speaker. To work therapeutically with people who project, it is important to support them to locate, explore and eventually express verbally the feelings behind the projection to encourage them to take more responsibility for their own actions (Lego 1996).

Splitting is an unconscious defence mechanism that 'compartmentalizes opposite affect states and fails to integrate the positive and negative qualities of the self into cohesive images' (Burgess & Clements 1997, p. 86). Parts of the fragmented self are experienced as 'bad' (Gardner 1996). Others in the environment are perceived to be 'good' or 'bad' at a particular time. According to the consumer's recognition of good or bad, some people are idealized (the good) and others are devalued (the bad) (Campbell & Poole 1996). The consumer appears to live in a black and white movie with different people displaying the exaggerated good or bad feelings or qualities during different phases of the unwinding film. Psychodynamic theorists consider that this defence mechanism originates in infancy when the child experiences one or more significant carers as both fearful and loving (Vaillant 1977). For the child to survive, the experience of hostility is split from the experience of caring. Splitting unconsciously separates good aspects of the parent from bad aspects of the parent so that the child 'copes' with the parent by dealing with him/her as if they are two separate people, depending on their expression of affection or hostility at the time (Masterson 1990). Managing inner and outer good and bad then becomes problematic for the person later in life.

As well as the outer workings of projection and splitting precipitating reactive and unhelpful behaviours from individual staff, sometimes negative responses can be acted out collectively in the form of in-groups and out-groups within the hospital unit or the community health team (Lego 1996). Conflict can arise as a consequence of consumer splitting or projection, whereby the staff act out (externalize) the internal good–bad and blaming dynamics of the person with the borderline personality disorder. This can

be damaging for the team and scary for the consumer as these dynamics are a re-enactment of behaviours experienced earlier in her/his life. To ensure that contradictory and nontherapeutic approaches to the consumer with a borderline personality disorder diagnosis do not occur, all members of staff have to be involved in developing, reviewing and adhering to protocols regarding acceptable behaviours, treatment parameters and the rights of consumers and staff.

According to Burgess & Clements (1997, p. 86), the overuse of splitting and projective identification defence mechanisms virtually 'guarantee problems in interpersonal relationships'. Projective identification is a complex unconscious defence mechanism that involves the projection of one's own negative feelings (say, hate) onto another person (Burgess & Clements 1997). The recipient of the projection now embodies the projected emotion, and becomes feared as if she/he is the emotion itself (in this case, hate). The anxiety levels of the projecting person are heightened when in contact with the other person, and they try to control the projection recipient by behaviours or words. When a consumer is feeling hate and projects it onto the nurse, then they will become afraid of the nurse and behave in ways which are likely to make the nurse feel anger or hatred. This is likely to feel like an attack (Lego 1996). An understanding of these mechanisms increases the likelihood that the nurse will not react unthinkingly to these provocative dynamics.

Vaillant's (1977) studies reveal that unconscious defence mechanisms worked as protective mechanisms in traumatized children during their early years, but interfered with later developmental challenges in relation to establishing viable trust and autonomy. Some common consequences of early unconscious defence mechanisms becoming inflexible and repetitive are discussed in the following section of the paper: these include identity diffusion, self-mutilation and attempted suicide.

Identity diffusion

Identity diffusion means that the person has a tenuous sense of self and does not feel secure as a person. To have a long-term awareness and feeling of personal inadequacy is emotionally and practically disabling at times. Identity diffusion is not merely a concept, it is a real life experience: such people feel profoundly lost and 'sense, but cannot understand the hollow core at the center of [their] life' (Masterson 1990, p. 81). Such experiences of emptiness or hollowness are very distressing.

An unclear sense of personal boundaries and disruptive relations with others can be a consequence of identity diffusion. These characteristics are commonly the sequelae of early childhood trauma or emotional abuse. The unclear sense of self is likely to emerge from parental intrusiveness of an emotional, sexual or controlling nature (this is sometimes called family enmeshment). A lack of recognition of one's own and colleagues' physical, emotional and social boundaries can result from physical, sexual or emotional invasion of the child's self and body (Long & Smyth 1998).

It may be useful to understand such dynamics as falling along a continuum, with the most damaged and vulnerable people receiving psychiatric treatment. Interpersonal actions, such as behaving in a helpless manner, telling the nurse what she/he wants to hear and behaving in dependent ways replicate childhood strategies to gain necessary assistance or attention (Lego 1996). It is easy for nurses to half understand these ways of interacting and describe them as 'seductive', 'dependent' or 'regressed'. However, such terms are at best descriptive (in the clinical sense) and do not create the possibility of interpreting the behaviours in ways that can provide constructive therapeutic guidance.

For the safety of both the nurse and the consumer when working with people with unclear boundaries, the nurse is required to develop a clarity about her/his own boundaries, manage her/his own anger and not seek personal gain from these vulnerable and pained people. Likewise, the nurse needs to develop an awareness of the real power differences between professionals and consumers and aim to be careful not to abuse their privileged position, as other authority figures are likely to have done in the past (Horsfall 1998).

Self-disfigurement

Acts of physical self-disfigurement include (for example) cutting the skin of the wrist, penis or breast, self hitting, head banging, deep scratching, excessive hair pulling, finger biting, breaking the skin with needles, piercing blood vessels, hand bleaching, burning self with cigarettes. People with a borderline personality diagnosis, especially those who were abused as children, sometimes inflict such injuries on themselves (Marcus 1998).

Responses to the sight of such self-inflicted wounds can include disgust, disbelief, horror, fear and shock. An aspect of personal self-management for nurses working in mental health settings is to own and process these ordinary human reactions. Such strong emotions have to be acknowledged and overcome (at least to the extent that the nurse is not overwhelmed) to work therapeutically with the wounded person. If this does not occur, nurses are likely to remain entangled in serial conscious and/or unconscious manoeuvres to attempt to defend against the strong feelings and end up emotionally wounding themselves.

Nurses experience threatening feelings and thoughts in associated with consumer self-mutilation (O'Brien & Flote

1997). It is therefore especially important for nurses to try to gain a constructive perspective about the likely derivation of such behaviours. According to consumer feedback, some nurses have been physically or verbally violent in response to client self-harming. One consumer recollects: 'I had done something that was detrimental to myself, but I still didn't need to be treated like that' (McGuiness & Wadsworth 1991, p. 53). Reacting to self harming, without thinking about the client's underlying pain and distress is not helpful to the client, or for the nurse's ongoing need for a sense of professional competence.

A major challenge for nurses working with people who disfigure themselves, is to consistently not reward unacceptable behaviours without resorting to trying to control or avoid the person. All of these responses (boundary invasion, inappropriate intimacy, controlling, anger, rejection or distancing) repeat previous and often long-term behaviours used by people in positions of power and family members in their attempts to 'deal' with the consumer. Because of this life history and circular negative interactions, the client fears both engulfment and abandonment by intimates and authority figures (Campbell & Poole 1996).

Marcus (1998, p. 363) says that the person who mutilates her/himself 'acts out the [painful] feelings, due to the inability to express or process those feeling states'. At some level our own strong emotional response to the consumer's bodily signs of damage, disfigurement and hurt, mirrors their inner chaos, pain and fear. Actions such as self slashing may be attempts to relieve pain, or to punish the self for shameful past experiences (Graham 1994). Guilt, self loathing, self punishment and attempts to deflect flashbacks – especially those arising from childhood sexual abuse – underpin much self-mutilation (Graham 1994).

Self-disfigurement is a form of acting out. Acting out occurs when a person relives or indirectly expresses unconscious feelings or conflicts through actions, rather than words. As acting out bypasses verbal self expression, the aim for nursing people who act out in the mental health setting is to teach them to recognize the distress experienced prior to the action and to express those feelings in words (Crowe 1996). That is, both the nurse and the client need to recognize feelings and gain a sense of self-control to increase positive actions, instead of reflexive reactions.

Eating disorders, violence against others and severe depression may also be seen as acting out via the body. Self-disfigurement is often an externalization of anger or other emotions that the person cannot yet name (Ross 1996). Similarly, anorexia and physical aggression towards others can be nonconstructive means of attempting to manage pain or tension and to gain some sort of control (Campbell & Poole 1996) over fear or self fragmentation. InFavazzo's (1989, pp. 139–40) exploration of patients' understandings of the personal consequences of self-mutilation, some of the following gains were articulated:

- tension release;
- returning to reality;
- regaining control of some aspect of self;
- expressing forbidden anger;
- escaping self-hatred associated with incest;
- aiming to diminish alienation from others;
- the sight of the blood provides emotional relief;
- the pain and the blood stop feelings of emptiness.

From these consumer comments, it is clear that self-harm is carried out knowingly with the intention of altering the emotional state that the person finds distressingly uncomfortable. Overall the result of physical self damage appears to be to provide relief and establish some feelings of personal control over life experiences.

It is important that nurses ask consumers what is happening in their minds to develop an awareness and understanding of the person's frightening inner life (Graham 1994). As a result of increased comprehension, nurses are likely to be less judgmental and work more sensitively with people who intentionally disfigure themselves (Gallop 1992). Lego (1996, p. 242) advocates a co-operative analysis of a self-harming episode to seek the consumer's understandings of the event and its experiential and emotional precedents.

These are complex circumstances for nurses to personally endure; and to work therapeutically with the person who is physically damaging herself or himself (O'Brien 1998). A balance of self-awareness and an understanding of other people's troubled behaviours is required. The challenges intrinsic to specific behaviours associated with people with a borderline personality disorder reveal the importance of developing a broad professional interaction repertoire. Such communicative and interacting styles need to range from empathic listening to the ability to make and assertively adhere to contracts (Stuart 1998). Flexible interaction styles also allow for more constructive responses to clients' fear, anxiety or anger (Marcus 1998).

Self-harm appears to be a coping mechanism that some people have found to be effective, at least in the short to medium term. The more the nurse is able to overcome their own fears in response to self damaging acts, and understand that the consumer is using them as survival strategies, the more therapeutic her or his interactions with the consumer will be.

Suicidality – a continuum

Some RNs draw a clear line between self disfigurement and suicide attempts: a consequence of this is the belief that

consumers who are deemed to be intent on killing themselves are more 'worthy' as patients than those whose pain results in self-injury that is unlikely to be fatal. Judging clients as unworthy of care mirrors the self-perception of many people with a borderline personality disorder and can therefore worsen the person's struggle with feelings of inadequacy and worthlessness (Lego 1996). In a therapeutic setting there is not a status hierarchy whereby some consumers are assumed to be 'not really suicidal' and therefore not valid recipients of nursing care.

To assist in understanding self-mutilation and suicide, these actions may be conceptualized as falling along a continuum (Stuart 1998). People who are suicidal or injure themselves are likely to be emotionally distressed, have life difficulties and/or be depressed. Survivors of childhood abuse and sexual assault frequently experience psychic pain, a profound alienation from self and a sense of disconnection from others that result in attempted suicide, self-injury or assaults on others (Hartman & Burgess 1998). Anger is likely to be common to all people who feel desperate enough to intentionally injure themselves. Not only are present levels of distress similar for people who are hospitalized because of a suicide attempt and those who self-mutilate, but the past experiences of both groups are likely to have been traumatic and/or developmentally undermining.

Amongst people with a personality disorder diagnosis who had completed suicide, one researcher found that they all had symptoms of depression or psychoactive substance abuse (Marcus 1998). The diagnosis of borderline personality disorder is not watertight: there are overlaps with mood lability, psychotic experiences and the blotting out of pain by use of legal, illegal or prescribed substances.

Where do tattoos, hair removal by waxing and body piercing end and self-mutilation begin? Alcohol bingeing, playing dangerous sports, using illicit drugs, driving a car at excessive speed and cigarette smoking, for example, are all potentially life threatening. These behaviours are socially endorsed and indulged in by people in most sectors of our society. Health professionals are not immune to depression or suicidal ideation, consequently a client who has attempted suicide may be felt to be especially threatening and fearful for some nurses (Stuart 1998).

The first priority when nursing a suicidal person is their safety. So that emotional safety is achievable, the nurse can assist the person to become aware of feelings, name them and co-operatively develop strategies to express distress more constructively (Marcus 1998). As self-mutilation is often a purposeful action for relief of anxiety or tension, the client's suicide attempt may also be purposive (Hartman & Burgess 1998). For people whose lives are full of pain and disrupted relationships, motives can include escape from frustration, failure or distress (Lego 1996). Hence, suicide attempts and ambivalence about life and death can have personal meaning (Hartman & Burgess 1998). Listening, being supportive, exploring antecedents and assisting the client's verbalization of pain and fear are important.

Contracts, or professional mutually agreed strategies, involving the steps that clients will take when they feel tension building, or anxiety escalating can draw on client strengths and plan to pre-empt future suicide crises. This is demanding and at times may feel like walking a tightrope. Ultimately a nurse cannot stop a person from killing themself, therefore an appraisal of one's realistic limits is helpful for all concerned (Stuart 1998). However, a nurse can develop understandings of feelings and unconscious dynamics that often underlie suicidal intent and action. This can allow the nurse to work intensively with a suicidal person; emotionally accompany her/him through their pain and anguish; and co-operatively develop strategies to gain some control over the person's present responses to distress and fear.

Conclusions

This paper argues that nurses need to develop a framework for understanding clients who self-harm and/or make suicidal attempts. Issues relating to the negative consequences of the over-use of the term borderline personality disorder along with associated phrases such as 'attention seeking' and 'acting out' have been raised. Some unconscious defence mechanisms that are likely to arise in childhood, often in response to trauma, have been explained to reveal some of their human self-preservation logic. Self diffusion, self-harming and suicidality are constructively reframed and explored with the intention of enhancing the provision of compassionate and helpful nursing care to highly distressed consumers.

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