Psychiatria Danubina, 2019; Vol. 31, Suppl. 3, pp 626-631 *Conference paper*

ATTITUDES TOWARDS A BORDERLINE PERSONALITY DISORDER UNIT - A SMALL-SCALE QUALITATIVE SURVEY

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SUMMARY

Background: *Springbank Ward, Fulbourn Hospital, Cambridgeshire and Peterborough NHS Foundation Trust, is a Borderline Personality Disorder (BPD) unit employing positive risk-taking, allowing for relevant psychological therapies to be carried out.*

The aim of this survey was to identify staff and patient attitudes to Springbank Ward. Previous research has not addressed the question of patient and staff perception of these therapeutic approaches.

Subjects and methods: *We used a qualitative open-ended semi-structured survey of staff and patients (n=2+4, respectively). We gathered information on the perception of the unit, staff, safety and the positive and negative aspects of the ward. Interview transcripts and participation notes were coded and categorised for emerging themes.*

Results: *The four main themes were: views on the unit: 'safe space', 'opportunity', 'community'; views on the programme: 'successful', 'skills-based', involving patients in their own recovery; views on staff: important part of the therapeutic process by delivering elements of dialectical behaviour therapy (DBT); views on safety: patients and staff feel safe in the context of positive risk-taking.*

Conclusions*: The long-term therapeutic programme offered at Springbank is perceived positively by both patients and staff. Involving patients actively in their recovery remains a powerful tool. The delivery of DBT by nursing staff contributes significantly to the positive perception of the unit. Positive risk-taking is perceived to be a good and safe strategy.*

Key words: *Borderline Personality Disorder - surveys and questionnaires - therapeutic community*

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INTRODUCTION

Borderline personality disorder (BPD) is a common condition, affecting around 0.4% of adults in the UK, and its cost to society reaches thousands of pounds per person (McManus et al. 2007, van Asselt et al. 2007). Yet, there is a lack of consensus about the cost-effectiveness of various BPD treatments, contributing to the high cost of the condition to society (Brettschneider et al. 2014). According to the most recent National Institute for Health and Care Excellence (2009) (NICE) guidelines, long-term management should focus on risk assessment, risk management and psychological treatment that is comprehensive and prolonged. Furthermore, NICE recommends dialectical behaviour therapy (DBT) programme in the community for women with BPD for whom reducing recurrent self-harm is a priority and to consider pharmacological treatment should be considered for treating comorbid conditions. Therapeutic relationships are very important – patients should be encouraged to take on the responsibility for their recovery and engagement with services (National Institute for Health and Care Excellence 2009, Birch et al. 2011).

One of the challenges in the management of patients with BPD is the risk of self-harm and suicidality. The traditional approach to acute self-harm and suicide is a vigorous intervention, aimed at monitoring and managing a patient's safety (National Institute for Health and Care Excellence 2004). However, for many patients with BPD who exhibit chronic suicidality this approach is harmful, traumatic and contributes to the prevention of emotional expression and distress communication, which became established over long periods of time (Krawitz et al. 2004; Birch et al. 2011). Instead, a harm minimisation strategy is proposed, consisting of a rapid non-judgmental response, aimed at exploring causes of distress, emphasising alternative coping strategies and the provision of clean materials that can be used in self-harm (Krawitz et al. 2004; National Institute for Health and Care Excellence 2004). The therapeutic community approach has also been shown to significantly reduce the incidence of self-harm (Birch et al. 2011). In that setting self-harm is seen as a form of emotional expression that transgresses a relationship boundary and an act of self-discharge from the community that can only be reversed by showing regret and intention to learn from the experience (Birch et al. 2011). All of these strategies can be seen as elements of positive risk-taking – the idea that in the management of chronically suicidal and self-harming patients the risk can never be eliminated, but professionally-indicated, short-term risk-taking ultimately results in a profound reduction in the long-term risk of suicide (Krawitz et al. 2004).

Springbank Ward in Fulbourn Hospital, Cambridgeshire and Peterborough NHS Foundation Trust, 'is a 12-bed in-patient recovery unit for women with a diagnosis of borderline personality disorder (BPD) who are struggling to cope with the demands of life outside of

hospital, despite the input from community psychiatric services' (Cambridgeshire and Peterborough NHS Foundation Trust 2018b). Admission criteria include: 'women between the ages of 18 and 65 who: have a primary diagnosis of emotionally unstable personality disorder (ICD-10 F60.3); are under the care of a psychiatric community team with an identified care coordinator and a responsible clinician (the responsible clinician may not be the care co-ordinator) (…); have tried but failed to benefit from general acute and community psychiatric services; are willing to be assessed for admission by the staff at Springbank ward; have a permanent place of residence; are able to identify goals they would like to work on whilst being an in-patient' (Cambridgeshire and Peterborough NHS Foundation Trust 2018a). Patients who pose a significant risk of harm to others, require management in a low or medium secure unit and/or are unwilling to engage with the therapeutic programme cannot be accommodated (Cambridgeshire and Peterborough NHS Foundation Trust 2018a). The therapeutic programme offered is usually 12 months long and is based on therapeutic activities and evidence-based interventions, which include DBT, arts and crafts, cooking and others (Cambridgeshire and Peterborough NHS Foundation Trust 2018c). The ideas of a therapeutic community and positive risk-taking are endorsed.

The aim of this qualitative survey was to identify staff and patient attitudes to Springbank Ward as an example of a BPD unit employing the principles of a therapeutic community and positive risk-taking.

SUBJECTS AND METHODS

Direct observation

Direct observation of staff and patients was undertaken over the period of 6 weeks in May and June 2018 as part of a medical student placement at the unit. It included participating in daily ward activities, including group therapy sessions, activity groups, meals, and free time.

Subjects

The goal of the study was to interview staff members and patients from the Springbank ward, Fulbourn Hospital, Cambridge, UK. The participants were not randomly sampled, as only consenting participants were interviewed. All of the patients and staff members, however, were included in the direct observation.

Interview procedure

4 patients (out of 6) and 2 staff members were interviewed. 2 patients who were admitted at the time of the survey were not available for participation. The patients interviewed had been inpatients for between 2 and 11 months. The staff members interviewed had worked there for between 3 and 5 years. The interviews took up to 20 minutes and were all conducted on the ward, in a quiet and private area. The participants were told that they were being interviewed for a service evaluation of psychiatric care and that the interviews are anonymous. The interviews were conducted in the last two weeks of the interviewer's six-week-long placement, so all interviewees knew the interviewer well and were aware that he was leaving the environment soon.

The questions were designed as unbiased, open-ended and unambiguous. Staff and patients were asked demographic questions, how they would describe Springbank to someone who did not know what it was, what works well, what could be improved, what the staff were like, how the ward compared to other mental health units, and how safe the ward was. Staff and patients were asked the same questions. New questions were added as the interview process progressed. Interviews were continued until a point at which no new themes were emerging.

Analysis

The content of the interviews was handwritten verbatim, during the interview by the interviewer. These interview transcripts and observation notes were then transcribed digitally. Transcripts and notes were then coded for relevant aspects. Codes were grouped together to form the main themes emerging from the survey. The relationships between the themes were examined.

RESULTS

The four main themes that emerged from this survey were: approaches to the unit itself, to the recovery programme, to the staff who work there, and to safety on the ward. All of these themes influence each other and merge to become the perception of what Springbank is and how it works. They all, however, address a subtly different aspect of the life in the unit and offer insights into how each of these parts individually contribute to the final product.

Attitudes to Springbank

It is clearly noticeable that all staff and patients are very proud of where they work or are being treated. The ward is being spoken of in superlatives, set as an example to others, and a hugely beneficial environment. It is described as a 'safe space' and an 'opportunity', where the patients can 'build a life worth living', a life 'without pain or suffering'.

The most frequently mentioned advantages of Springbank are patient involvement and working together. During daily activities on the ward patients, especially those who have been on the ward longer than others, help those who are struggling. In those touching displays of peer support one can see real non-patronising care for each other. The patients themselves recognise that one comes to Springbank to 'build your own reco-

very' in a community where 'everyone works together'. This seems exceptional, considering the difficulties faced by patients who are unwell enough to be referred to specialist units. The patients find it pleasantly surprising that the staff 'encourage [them] to make decisions about your own care'. Some explained that, initially, they found it difficult to settle in and make friends, but emphasised that support was offered for them to stick to their values in the face of adversity, which helped resolve these issues.

Springbank is universally recognised for the uniqueness of psychiatric care it offers in terms of the use of dialectical behaviour therapy (DBT) and positive risk-taking. 'You can come and go as you please, if you have a risk assessment. Sections are very rare. Everyone who is here wants to be here. You're never here against your will.' It was truly emotional to see the gratefulness in one patient's eyes when, for the first time in years, she was not detained under a section of the Mental Health Act, merely days after arriving at Springbank. The patients praise the 'willingness to try new things and approaches to recovery'. Many are surprised that 'there are so many people out there who are struggling and don't even know there is this amazing therapy that works so well'.

Staff members universally disclose that prior to May 2015 'it was very different to what it is now'. 'We had to be one-to-one all the time, [the patients] were self-harming all the time'. 'There were not enough staff (…), it was horrendous'. The transformation of the recovery programme, undertaken as part of a huge team effort and a change in the leadership of the ward, was the turning point. The ward was changed 'into a therapy-based ward', 'it started to get better'.

Nowadays, staff and patients alike consider Springbank 'the best mental health ward in the f…ing world' and voice these opinions in informal conversations. They appreciate that it is the uniqueness of the community that allows them to openly bring up these views in communal areas.

Attitudes to the recovery program

One of the main factors contributing to what everyone describes as a successful ward is Springbank's unique program. It includes DBT, praised for the skills it teaches patients, which 'can be used in real life'. All patients follow a busy timetable, with many activity groups, such as sensory group, creative group, goal-setting group, cooking, and many others. Together they 'teach you to express emotions in creative ways, (…) and work towards achieving goals in every aspect of your life'. In addition to that, there are a multitude of activities outside of the ward, including camping, trips to festivals, open mic nights at local cafes, etc. All this means that 'the patients are not sitting festering in their own problems'. One staff member, who works at a different unit on the same site, said 'Whenever I have a shift at [the other unit] I think to myself – can we not drag [the patients] out of their rooms? Make them do something? [The other approach] clearly doesn't work, so why do we keep doing it?'. Those who have been taking part in the program for a long time appreciate how well thought out it is. They say that 'everything on the program has a purpose' and even though sometimes one needs to force themselves to participate, 'everything gives you a real sense of achievement when you look back'.

Some patients confess how challenging the program is initially. 'Having to change myself, how I think, my habits – it's difficult'. During my time at Springbank I could see how the program is also constantly developing to match the patient's needs. 'The only thing [that could be improved] (…) – my partner could be more involved. It's gotten better whilst I've been here and he knows that he can call and ask questions. We had a consultation together recently, but it's still something that's not explicitly offered as part of my program', said one patient. Within a week from this conversation an evening carer support group at Springbank was set-up as a result of this feedback.

It is a universal conviction at Springbank that the program is incredibly successful. Those who have recently started their time at the ward 'hear about patients who were previously here (…) and were acutely unwell [at the beginning] who had BPD removed from their list of current diagnoses [after completing the program]'. Others, who have been there for a while appreciate that 'it's shaped [them], it saved [their] life'. Some of the patients get volunteering jobs, start college courses and jobs whilst at Springbank – 'I never thought I would manage to do that', confesses one lady. These are not temporary successes – previous patients visit the ward often and act as a positive example for the current Springbank residents. Patients who leave are convinced they 'will not ever be going back to the hospital', they say it is the 'start of a new life. A happy life'.

Attitudes to staff

One of the main advantages of the staff who work at Springbank that is brought up by patients is that the mental health nurses are involved in DBT. According to one staff member, this helps encourage the patients to participate in various nurse-led groups, which are considered much more of an integral part of the recovery process than before. The additional benefit is that the skills taught in DBT become much more woven into the daily life on the ward. 'All the staff are trained in skills, so all day, every day, you have access to DBT', says one patient.

At the same time, it is very easy for the patients to bond with the team, because 'everybody is themselves (…). They feel like they can bring a part of themselves to work (…) They can be human'. Another person adds that the staff 'work with patients on the same level, rather than as figures of significant authority' and that the patients are equal 'even with the doctors'.

In her thank-you letter to the team that she read out on being discharged, one patient said, 'When my mum and I were looking at this ward's website and I saw there are over a dozen nurses and another dozen healthcare assistants, I thought you'd all suck, 90% of you will be shit, and I'd only get on with a handful of you - how wrong I was!'. Indeed, the staff at Springbank are much loved by everyone. Any disagreements between staff and patients, which are bound to happen in any community, are dealt with very sensitively and with continued support for the staff.

Attitudes to safety

The perception of safety at Springbank is of particular interest, given the risk-taking approach. In their interviews everyone said that they feel completely safe at the ward. 'Sometimes I even forget that I'm in a hospital and that I do need to be careful', says one staff member. Paradoxically, this feeling of security seems to have come with increased freedom for the patients and the trust that is currently placed in them. 'I feel very confident, because I know [the patients] well and they feel very safe as well'.

The patients do indeed all report feeling safe, both from themselves and external factors. One patient describes it as: 'Safety [at Springbank] is the patient's responsibility. So although there are some things in place to prevent serious harm, like no sharps and stuff, it's mostly – or entirely – the patient's responsibility to keep themselves safe'. It is recognised to be hugely beneficial, as the patients 'work towards reducing self-harming and self-destructive behaviour by choosing not to self-harm even when you have the opportunity to'. In other settings, 'if [the responsibility] is taken away from you, you never learn to look after yourself'. Some staff members nevertheless think that they are overly protective, but that is not the perception of the patients, who recognise that they need the safe environment to recover. 'Not only will I be safe, but I will be saved [at Springbank]', says one of the patients.

DISCUSSION

It has been suggested for a long time that brief patient-initiated admissions to hospital may be superior to prolonged stays in this group of patients (Nehls 1994). Such treatment plans play an important role in crisis management, as well as in the breaking of cycle of repeated hospitalisations, but have been criticised, due to the lack of permanent effect on the difficulties that patients experience on discharge in community (Nehls 1994). The gold standard is currently to bridge that gap with dialectical behaviour therapy delivered outside of hospital (National Institute for Health and Care Excellence 2009). While DBT is a very expensive therapy to deliver – the cost of each individual session is about two times higher than that of a visit to a psychiatrist and the sessions need to be delivered very often – it is very effective at reducing the total cost to society due to BPD (Wagner et al. 2014).

At Springbank patients are subject to a prolonged voluntary admission to a therapeutic community, whose purpose is to equip them with tools to deal with their difficulties in function in society. The financial burden of DBT delivery is partially reduced by providing training in this type of therapy to the nursing staff, who support the psychologist in delivering it to patients. This model of care, where nursing staff routinely offer psychosocial interventions, is not at all new and has been suggested as the key to improving patient outcomes, but remains a rare occurrence (McCann & Bowers 2005. Mullen 2009).

The benefits of this approach are not only the delivery of very effective psychotherapy at a reduced cost, but also substantial benefits to the staff-patient relations. Understanding DBT increases staff empathy and facilitates a more optimistic therapeutic outlook, which are suggested to be the key to improving staff participation in the recovery programme (Hazelton et al. 2006). This is particularly important, as even staff who work with patients with BPD have been shown to have limited understanding of the aims and process of recovery (Dean et al. 2018) and both historically and currently, borderline personality disorder remains one of the most stigmatised diagnoses, also among healthcare professionals (Gallop et al. 1989, Sheehan et al. 2016). Finally, psychotherapy training for staff members significantly benefits the staff themselves – it has been shown to reduce stress, anxiety and burnout rates, which are very common in those working with patients who are difficult to treat (Caruso et al. 2013).

It is in this environment where staff members empathise with and understand patients, that the positive risk-taking approach to chronic suicidality is being implemented. Despite being proven to reduce self-harm and suicidality (Birch et al. 2011), this approach is still not widespread. Krawitz et al. (2004) in a relatively recent paper explored why that is the case and found that clinicians agree that risk-taking is in the patients' best interest, but fail to implement it in their practice. The authors identify that the predominant reason is the fear of medicolegal repercussion in the case of patient injury or death, but the patients themselves express overwhelming support for this strategy.

Limitations

Despite this survey providing useful insight, it is not without limitations. Firstly, it was conducted on a very small sample of patients and staff. Secondly, since the questions were open and qualitative, no quantitative data could be obtained and no statistical analysis was conducted. Thirdly, since the interviewer was a temporary member of the clinical team, the interviewees may have had reservations in disclosing some information – although they were instructed that the survey was confidential and the interviewer would cease to be part

of the team at the end of the study. Moreover, the participants do not constitute a representative sample, as they have all worked or participated in the recovery programme at Springbank and the results of this survey can only be extended to a wider population to a certain extent.

CONCLUSIONS

The findings of this study highlight a number of interesting points about staff and patient attitudes to Springbank Ward. Firstly, although not formally recognised as an evidence-based treatment, the long-term therapeutic programme offered at Springbank is thought to be effective in women with BPD who have failed to benefit from acute and community psychiatric treatment. Secondly, the delegation of part of the responsibility for recovery to the patient increases their engagement and satisfaction with the service, even if in the short term it may increase anxiety. Part of that ownership of the process of recovery is positive risk-taking with relation to chronic self-harm and suicidality, which in fact increases the feeling of safety. Thirdly, the bilateral positive relationship that the patients enjoy with members of staff is both psychotherapeutic and personal.

Most importantly, however, this work outlines the importance of further study of successful strategies to manage patients with BPD. Little is known about how best to deliver DBT – in community, as an inpatient in a therapeutic community, by psychologists or multiple professionals – although it appears that training staff in this type of therapy is beneficial. In addition, educating clinical staff about the benefits of professionally-indicated risk-taking in the management of BPD and ethico-legal advice related to it is needed. Additional research is required on the indications for long-term inpatient therapeutic interventions, such as the one offered at Springbank, and how they fit into the current framework of short hospital stays for patients with BPD.

Acknowledgements: *None*

Conflict of interest: *None to declare.*

Contribution of individual authors:

Jakub Nagrodzki – design of the study, data collection, data analysis and interpretation, manuscript writing.

Jorge Zimbron – design of the study, manuscript review.

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