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THIS ARTICLE HAS BEEN DOUBLE-BLIND PEER-REVIEWED

Improving the management of women with borderline personality disorder

This article describes how a new therapeutic approach improved treatment of borderline personality disorder

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An inpatient service for women with borderline personality disorder adapted a therapeutic approach developed for use with outpatients. Mentalisation-based therapy helps clients to understand the meaning of their own behaviour and that of others, and allows positive risk-taking. It has led to real improvements in clients' progress towards more independent life.

INTRODUCTION

New Dawn is a unique specialist service providing intensive, long-term treatment for women with borderline personality disorder (BPD). Operating from Cygnet Hospital Bierley, outside Bradford, the ward treats complex cases with multiple difficulties such as eating disorders, substance misuse, attention-deficit hyperactivity disorder (ADHD) and short-lived psychosis.

The service was established in 2006 due to concerns that traditional approaches for this client group were unsuccessful. These concerns were echoed by changes in government thinking (National Institute for Mental Health in England, 2003a; 2003b). Both described areas of good practice and marked a change in approaches and

responsibilities for mental health services regarding personality disorders.

Clients with BPD can evoke strong and often negative responses from nurses and other professionals, many of whom perceive this group as difficult and demanding. In the past, a diagnosis of personality disorder was equivalent to being deemed untreatable and exclusion from services was common. The result was a national deficit in services, resulting in inappropriate treatment and placement of clients, often through A&E, the prison service or high-security environments.

MENTALISATION-BASED THERAPY

Cygnet Heath Care operates three New Dawn services. The unit in Bierley has adopted a structured psychotherapeutic programme, underpinned by mentalisation-based therapy (MBT) (Bateman and Fonagy, 2006). This was initially developed for use on an outpatient basis (Bateman and Fonagy, 1999), and Bierley has been unique in adapting MBT to an inpatient setting.

Bateman and Fonagy (1999) showed that MBT could reduce frequency and severity of self-harm behaviours and help with global functioning, depressive symptoms and relationships, all with sustained benefits. The impressive results on New Dawn reinforce this (see Fig 1 on nursingtimes.net).

Mentalisation is a normal ability: it involves how people see themselves and those around them, and is central to communication and relationships. In essence, it highlights the fact that how people behave is linked to

their feelings, beliefs, desires and needs. So, when people interact with the world around them, they use understanding of themselves and others to make sense of this.

People with BPD often misinterpret their own thoughts, feelings and behaviours as well as those of other people. MBT focuses on looking at these in the present, through both individual and group work. It adapts a form of interview/questioning style derived from both reflexive and relational questions of the systemic model, in particular the Milan/post-Milan schools of systemic theory.

Developing the capacity to mentalise helps people to regulate emotions and build and maintain healthy relationships. Emotional arousal reduces the capacity to mentalise, while feeling calm and safe in a therapeutic relationship enables clients to explore their mind and those of people around them, to better understand the meaning of behaviour.

OTHER THERAPIES

While New Dawn focuses on MBT, other therapies are provided to help develop clients' skills and address traumas they may have endured. This approach involves a variety of techniques such as: eye movement desensitisation and reprocessing (EMDR); meditation; occupational therapy; guided imagery; body psychotherapy; art psychotherapy; and music therapy. It also includes yoga, physical exercise, healthy eating and smoking-cessation programmes. There are opportunities to pursue further education, voluntary work and hobbies, with emphasis on improved quality of life and a gradual move towards independence.

POSITIVE RISK-TAKING

The team appreciates the need for positive risk-taking. Most notably, they generally avoid implementing special observations as a response to self-harm, and instead use harm-minimisation interventions, engaging clients in intensive therapy.

Clients are not required to sign 'no-harm contracts', which rarely work in BPD. Practitioners believe enforced agreements

BACKGROUND

- Borderline personality disorder affects 2% of adults, 75–90% of whom are women (Warne and McAndrew, 2007).
- Three-quarters of women with BPD have a history of trauma including sexual abuse, childhood neglect, physical abuse and domestic violence.
- With this in mind, New Dawn decided to develop a service that catered specifically for women's needs, maintaining privacy, dignity and respect in a safe environment.

tend to make clients feel vulnerable and can, therefore, be perceived as setting them up to fail, prompting feelings of rejection and abandonment. This instigates cyclical self-harm behaviour.

While self-harm is never encouraged or assisted, it is tolerated and recognised as an expression of acute psychological distress clients undertake with the intention of helping rather than killing themselves (Sutton, 2007). Staff believe completely preventing self-harm can be counterproductive and even dangerous. Instead they address this over an extended period of time.

Practitioners focus on clients' strengths, giving them choices and enabling them to work towards greater autonomy. Clients are taught about wound care and risk of accidental death due to self-harm, as well as the need to alert staff either during or immediately after self-harm to facilitate prompt interventions.

It is essential that clients are not judged or rejected due to such challenging behaviours, but are engaged by knowledgeable, calm, non-judgemental and non-punitive staff. At a time of crisis, which may result in self-harm and aggressive behaviour, practitioners try to use verbal de-escalation as much as possible, avoiding the need for seclusion or rapid tranquilisation where possible.

CLIENT INVOLVEMENT

Particular importance is placed on clients participating in regularly reviewing and planning their care, giving them ownership of it. Staff help them make decisions and engage them in positive therapeutic work. For example, clients do not lose section 17

leave, nor would they be prohibited from participating in therapeutic activities simply because they have self-harmed or been aggressive, unless there is major concern of escalating risk. The multidisciplinary team work closely together and nurses are empowered to make decisions and discuss matters with the medical team. Family members and carers are also involved.

CLIENT PROGRESS

When clients have developed sufficient emotional skills through MBT, practitioners gradually begin to use trauma-focused therapies to probe the root cause of their difficulties. This is often the most challenging and difficult part of treatment but arguably the most important. As they move through the programme, many move towards our step-down unit, an open environment suitable for clients who have made significant progress. This provides an ideal stepping-stone between a secure ward and an eventual return to independent living.

Women on this ward have more freedom and autonomy, while continuing to participate in the New Dawn programme.

STAFF CHALLENGES

BPD presents conceptual and therapeutic challenges for healthcare professionals. Staff are supported through regular supervision by an external clinical psychologist who is experienced in BPD but does not become involved with clients on New Dawn, to ensure objectivity.

As a team, practitioners encourage mentalising relationships with each other, similar to the way in which they do with clients. This helps maintain a sense of cohesion and support, whereby they are less critical of each other, especially when incidents occur. They do, however, acknowledge they are only human and aim to learn from incidents rather than allowing them to divide the team.

Risk assessments, care plans and management plans are discussed. Staff talk openly about their feelings in supervision and handovers. They aim to lead by example, coping better with difficult emotions by remaining calm when a client loses control, demonstrating empathy, setting clear boundaries and not responding in paternalistic ways.

Like any service, practitioners have faced their own challenges and it was difficult to

change people's attitudes to working in a new way. Many staff are initially anxious about positive risk-taking, for fear of litigation. Staff from other wards sometimes struggle with this approach due to poor understanding of self-harm, BPD and the rationale behind our methods. This can be overcome through education, supervision and rotating staff between wards so they see how we work and appreciate the positive results.

CONCLUSION

Many women have moved through the care pathway and are able to participate more readily in the community, in preparation for discharge. Renewed interest in activities, starting voluntary/paid work and training are maintained beyond discharge and promote greater confidence and self-esteem, and improved quality of life. The net result is reduced likelihood of a relapse and subsequent return to care. ■

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IMPLICATIONS FOR PRACTICE

The service has had significant positive benefits for clients:

- Self-harm incidence and severity have greatly reduced;
- Carers, relatives and partners report increased self-esteem, self-confidence, self-worth and improved relationships;

- Clients report an improvement in their depressive symptoms. This is shown by how many have now taken up voluntary and paid work, education, hobbies and training, which they say they would never have dreamt of before following the New Dawn programme.