
Patients with borderline personality disorder need tailored emergency care

PERSPECTIVES

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There has been considerable pessimism surrounding the treatment potential for borderline personality disorder, but there is growing evidence to support the efficacy of tailored care.



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Patients with borderline personality disorder are often regarded as ungrateful and difficult to treat. The stigma associated with personality disorders in general is well documented, and people with such diagnoses are believed to be the most stigmatised group with a mental illness [\(1\)](#).

Some patients who are considered to be acutely suicidal by admitting doctors are denied admission to a psychiatric unit or are quickly discharged. As discussed in another article in this issue of the Journal of the Norwegian Medical Association, we believe that this practice reflects an oversimplified approach and a lack of individual assessment [\(2\)](#).

Experience with the user group at the Norwegian National Advisory Unit on Personality Psychiatry has brought to light many examples of ill-conceived comments made by mental health practitioners, such as 'Being in an emergency unit is no good for people like you' (3). Patients are sometimes pressurised into being discharged at the earliest opportunity, before any decision has been made about interventions that may help them. Patients also report that staff attitudes change dramatically in cases where the diagnosis is changed to, for example, bipolar disorder or complex post-traumatic stress disorder (3). Only then are they listened to and given help with the crisis they are struggling with. Similar experiences have also been reported in somatic wards, where patients have been admitted following a serious suicide attempt shortly after being discharged from a psychiatric unit.

Many patients who are admitted to a somatic ward after attempting to take their own life are allowed to stay for a day or two after the somatic treatment is completed in order to give them time to feel mentally stable before going home. There is no reason to believe that such short-term care promotes regression or leads to more suicidal behaviour. It is therefore almost unfathomable to practitioners in somatic wards that patients experiencing a substantial degree of suffering cannot be taken care of in an emergency psychiatric unit in a crisis situation. The point can be illustrated by drawing a parallel from somatic medicine: patients with COPD are not denied admission to a medical ward if their lung function deteriorates, since their lung disease is chronic. When there is an acute suicide risk, adequate protection must be provided.

Challenges in emergency units

Suicidal crises and self-harming behaviour are typical symptoms of borderline personality disorder and are common reasons for admission to emergency psychiatric units. The staff are often anxious that a patient will carry out their plan to take their own life. Consequently, staff's efforts to control the patient's behaviour can end up overshadowing the focus on helping the patient to cope with difficult emotions associated with the ongoing crisis.

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The interaction with the patients impacts on the practitioners. Some staff may be idealised, while others are devalued, and some can be the subject of both phenomena. This can lead to staff feeling unfairly treated, powerless or incompetent, or that they are categorised as either 'good' or 'bad' by the patients (4). Such countertransference responses are found in all therapeutic relationships. Rejecting the patient is a common way for staff to fight back or

protect themselves, and this can seemingly be rationalised through statements such as: 'This patient cannot be allowed on our ward because he ruins the treatment environment' (4).

Patients can be aggressive and unruly. The situation can be further complicated by substance abuse, and can often become critical during hospitalisation. Aggressive behaviour is high-risk and difficult to deal with, and can easily be regarded as 'exasperating', but it is important to recognise that such behaviour is a sign of a serious inability to self-regulate.

What should we do?

Patients often have strong emotional responses, and self-harm is sometimes an attempt to regulate emotions (5). Their ability to think about interpersonal events in a balanced and flexible way is severely impaired in stressful situations (mentalisation difficulties). Vulnerability to rejection is also a fundamental problem for many. Thus, self-harming behaviour and suicide attempts constitute core symptoms of this condition and should therefore be addressed without judgment and with an open attitude, characterised by transparency, clarity and empathy (4). Helping to identify problematic response patterns and vulnerabilities is also important.

In recent years, several specialised outpatient treatment approaches have been recommended. These psychotherapeutic treatment programmes should have a duration of at least one year, and should focus on the underlying problems and include treatment plans, crisis plans, psychopedagogical interventions and structured, targeted and tailored psychotherapy. Dialectical behaviour therapy (DBT), mentalisation-based treatment (MBT), schema-focused therapy (SFT) and STEPPS/STAIRWAY are specialised approaches established in Norway. These treatments have documented efficacy, showing a reduction in self-harm, fewer hospital admissions and less general psychopathology (6–9).

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Recent years have also seen a focus on defining the role that short-term voluntary hospital admissions can play in crisis situations (10, 11). Crisis admissions can be part of a structured treatment plan, where patients are involved in the planning process. The length of stay is a few days. Some interesting initiatives aimed at emergency psychiatric treatment for this patient group have been carried out in Norway, including in Levanger and Namsos (12, 13). In Levanger's uncontrolled study, patients were admitted for short, planned stays over the course of one to two years. The result was a reduction in self-harm and emergency admissions (12). In Namsos, a four-step treatment model has been introduced. If the interventions outside the psychiatric unit in the first three steps are unsuccessful, staff can offer a short-term crisis

admission, where the patient is involved in setting a goal for the stay. As a general rule, patients remain in the unit for three days – preferably without the use of restrictive measures such as isolation, etc. – during which time active efforts are made to prepare or tailor a crisis plan. No changes are made to established outpatient treatment programmes (13). Despite a limited evidence base, it is widely believed that the preparation of crisis plans and planned crisis admissions can reduce the need for emergency admissions (14).

Strategy improvements

A useful strategy for reducing the need for emergency in-patient admissions is to construct alternative interventions around the patient. Safe, predictable and accessible follow-up is important.

The treatment offered in an in-patient unit is often unsatisfactory, and many patients report little benefit from hospitalisation. There is a risk of patients only being 'stored' in the unit. However, it is possible to change this by, for example, clarifying which issues need to be addressed during their stay. A key factor is staff competence (15). A literature review of qualitative studies showed that patients viewed being listened to, talking to staff and fellow patients, getting a break from daily life and gaining a sense of safety and control as positive experiences. Negative experiences were attributed to lack of contact, negative attitudes and lack of knowledge among staff, sectioning and poor preparation for discharge (16).

Admission to an emergency unit can be incorporated into a patient's treatment programme, but this requires the practitioners in the emergency unit and outpatient clinic to reach a consensus on how the patient should be treated (17). It is also recommended that agreement is reached with the patient on a clear goal for the stay, including how long it should last, and that a well-defined follow-up plan is in place at the time of discharge (4). The work in the ward must be carried out according to well-defined and well-structured parameters, and as well as having clear boundaries, these must be transparent and predictable (4). The staff must have up-to-date knowledge about borderline personality disorder so that they can treat the patients with respect, and show interest and understanding. Through guidance, they can be trained to be aware of their own responses and not let them impact on the patients.

The symptoms of borderline personality disorder usually diminish somewhat over time. This particularly applies to dramatic factors such as self-harm and suicide attempts (18). If patients exhibit a severe level of self-harm or are acutely suicidal, it is important to help them survive the crisis (4). Helping patients in crisis situations, whilst simultaneously limiting their period of hospitalisation without rejecting them is a balancing act.

A study in Switzerland showed how a five-day period of hospitalisation, which entailed psychodynamic therapy for patients with borderline personality disorder in an acute suicidal crisis, led to a significant reduction in subsequent

re-admissions within a three-month follow-up period (19). This general hospital ward has eight beds and is an example of how it is possible to tailor hospital stays for this patient group.

The attention should be focussed on the interpersonal circumstances that triggered the crisis as well as the patient's feelings and thoughts about them. The systematic treatment of the personality disorder should be based on outpatient care, and emergency stays should aim to help patients regain their emotion regulation and ability to think more flexibly about themselves and their relationships with others (mentalisation) (5). Attempts must be made to maintain contact with the responsible outpatient practitioner during the patient's stay in hospital.

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