

# Preventive Psychiatric Admission for Patients With Borderline Personality Disorder: A Pilot Study

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**PURPOSE.** *The purpose of this study was to establish the preliminary effects of preventive psychiatric admission of patients with severe borderline personality disorder (BPD) on the rate of agreement over treatment, patient service use, and patient views on the intervention.*

**DESIGN AND METHODS.** *A retrospective pre-post test design with quantitative measures and qualitative interviews was used.*

**FINDINGS.** *Agreement over treatment increased substantially and significantly, and services use decreased substantially, yet not significantly. Patients were highly content with the intervention.*

**PRACTICE IMPLICATIONS.** *Preliminary results indicate that preventive admissions may be easy to use and cost effective with severe BPD patients in mainstream psychiatric services, but more research into the intervention is needed.*

**Search terms:** *Acute care, care pathways, mental health, nurse–patient interaction, psychiatric nursing, qualitative approaches*

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**B**orderline personality disorder (BPD) is a relatively frequent psychiatric disorder with an estimated prevalence of 2% in Western countries, mostly among women (70%). The severity of the disorder is exemplified by the fact that up to 10% of patients commit suicide (Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004). Patients experience an incoherent and vulnerable sense of self that is easily disrupted by (perceived) dislike or rejection by important others. A subgroup of patients frequently engages in self-destructive behaviors like self-harming, attempted suicide, or severe substance abuse. BPD often occurs together with other psychiatric disorders like anxiety, depression, substance abuse, posttraumatic stress disorder, and eating disorders. Treatment is becoming increasingly evidence-based, but implementation is limited; many patients still receive general psychiatric care (Lieb et al., 2004).

Due to the physical consequences of many of the aforementioned behaviors, BPD patients are also found in various general healthcare settings (Frankenburg & Zanarini, 2004; Trimpey & Davidson, 1998). As such, these patients are high users of health services (Comtois et al., 2003). Psychiatric appointments, both scheduled and nonscheduled (including out-of-hours crisis intervention), make up a substantial part of this service use. Yet, frequent or prolonged inpatient psychiatric admissions account for the highest costs (Bateman & Fonagy, 2003). Apart from their large

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expense, psychiatric admissions have been found to have possible adverse effects: regression and iatrogenic dependency have been reported (Paris, 2004). Since mental health professionals often oppose psychiatric admission, conflicts between patients and professionals easily arise over this issue (Hoch, O'Reilly, & Carscadden, 2006).

Such power struggles appear to be detrimental to the already fragile therapeutic alliance with these patients. Indeed, many health professionals find it difficult to work with BPD patients (Cleary, Siegfried, & Walter, 2002). Studies in different countries have repeatedly shown a pattern of negative attitudes of nurses toward BPD patients (Gallop, Lancee, & Garfinkel, 1989; James & Cowman, 2007). Most attention has been paid to the difficulties of inpatient nursing of BPD patients (Bland, Tudor, & McNeil Whitehouse, 2007; Nehls, 1994). There is some evidence that long-term inpatient admissions reinforce destructive behaviors by BPD patients, which nurses may find particularly hard to understand and tolerate.

### Background

Taking into account the high service use of BPD patients and the discontent of both patients and professionals over treatment, professionals in a Dutch community mental health center (CMHC), with both outpatient and inpatient facilities, developed a structured intervention, offered to BPD patients who used inpatient facilities frequently or had been admitted for a long time. The intervention consisted of a so-called preventive psychiatric admission on the open unit of a ward for general acute psychiatric admissions. The literature reports on one somewhat comparable intervention, consisting of providing self-harming adults and adolescents with a "green card" to gain rapid access to a psychiatric professional or hospital (Cotgrove, Zirinsky, Black, & Weston, 1995; Morgan, Jones, & Owen, 1993).

In the intervention the patient is offered a series of admissions over the next 6 months, instead of repeated

negotiations in times of crises (usual care). These admissions are scheduled in a frequency dependent on the individual patient's previous inpatient service use. For instance, a patient who had been admitted 12 days in the previous 6 months was scheduled for a monthly admission of 2 days during the following 6 months. The developers believed that basing the schedule on previous service use would recognize the patient's current need for care, thus preventing power struggles over the amount of care to be offered. Furthermore, the patient would no longer have to convince professionals of the severity of the crisis (in order to gain hospitalization), which might prevent more or heavier crises. Through the prearranged admission dates, patients may be able to delay crisis until the next scheduled hospitalization, and thus to increase control and coping and to facilitate ambulatory treatment. Hence, the goal of this intervention is to facilitate ambulatory treatment through limitation of crisis hospitalizations and disagreements between patients and professionals. A more distal goal is to reduce the need of psychiatric admissions in general through learning to delay admission by coping with crisis.

By indeed guaranteeing the admission at the prearranged moment, the patient is able to experience safety and develop trust. Also, patients are expected to show up at the admission unit, regardless of their perceived need for it at that time. Thus, the learned association of crisis and admission is diminished. The view that these patients need a long-term commitment with possible short-term but time-limited admissions differs from the traditional one that these patients should not be admitted at all. This attitude strongly adds to the patient's feeling of safety with psychiatric professionals, which often is limited due to previous experiences.

When not showing up or when an acute admission takes place, the intervention is immediately discontinued and care as usual is resumed. This response is discussed beforehand and labeled not as failure or punishment but as an indication that the intervention is not working and should thus be ended. Seemingly contradictory, this consistent policy helps to increase

trust and safety for the patient since the treatment team proves to be a reliable and steady partner. The intervention can only be started after intensive contract negotiation with both the patient and his or her primary support system, which serves the aims of making the intervention truly the patient's choice and building the therapeutic alliance.

### Design and Methods

Using a mixed-methods pilot design, we aimed to establish the effects of a preventive psychiatric admission system.

### Sample

Each patient between 18 and 60 years of age who received treatment in the CMHC, with a formal DSM-IV diagnosis of BPD and a history of repeated or long-term admissions was asked to participate in the program. Data were examined for patients who enrolled in the intervention from 2000 through 2006. During this period, 13 patients enrolled, of which one did not meet the inclusion criteria and one could not be contacted due to psychiatric instability (according to the primary therapist). All remaining 11 provided informed consent to collect service-use data and to measure agreement over treatment, while 8 agreed to participate in an individual interview. All participants were women, with a mean age of 43.55 years (range 24–61).

### Data Collection

Quantitative data on service use were obtained through searching paper and electronic administrative records, cross-checking these with individual patients' files. For each patient, data were collected for a period of 6 months just before the intervention and the first 6 months of the intervention itself. The several sorts of services were divided into three categories: low-intensive outpatient care (including scheduled outpa-

tient appointments, telephone and e-mail contact), high-intensive outpatient care (including nonscheduled crisis appointments and prolonged crisis intervention by others than the primary therapist), and inpatient care (including all inpatient days).

Quantitative data on the quality of the therapeutic alliance were obtained through asking the professional to rate the degree of agreement on content and form of the treatment. This was rated on a 7-point Likert-scale, with 1 indicating a complete lack of agreement and 7 indicating perfect agreement, both pre- (retrospectively) and postintervention. Two participants had to be excluded since the present therapists were not involved in their care before the intervention and thus were unable to rate preintervention agreement.

Qualitative data on patients' experiences were obtained during individual semi-structured interviews (mean length 45 minutes) that were guided by an interview schedule. The main questions in these interviews were how patients had experienced the intervention and how it affected their relationships with mental health professionals and their daily lives.

### Data Analysis

Quantitative data were analyzed using the nonparametric Wilcoxon Signed Ranks Test, since the sample was small and data were not normally distributed. Due to uneven distribution of high-intensive outpatient contacts, two categories were constructed (outpatient and inpatient service use). Since outpatient contact data of two participants were incomplete, they had to be excluded. Effect sizes were calculated by dividing the standardized z-score by the square root of the number of observations ( $r = z/\sqrt{n}$ ; Field, 2005).

Qualitative interviews were audio-taped, literally transcribed, and all text was manually coded through thematic analysis (Joffe & Yardley, 2004), using qualitative data analysis software (MAXqda Qualitative Data Analysis Introduction. Comsult, Sozialforschung, Berlin, Germany). The primary researchers each manually coded three interviews and then discussed the

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results. After several rounds of recoding and discussing differences, a code-tree was developed that was used for analysis of the remaining five interviews. The analysis was descriptive in nature, without the aim of building theory or providing a complete phenomenology of the patients' experiences.

### Ethical Considerations

The research project was approved by the management of the CMHC and the institutional review board that the first author was affiliated with.

### Results

From Table 1, it can be concluded that outpatient contacts decreased in number ( $r = 0.40$ ;  $z = -1.188$ ;  $p = 0.24$ ) and total minutes ( $r = 0.38$ ;  $z = -1.125$ ;  $p = 0.26$ ) but increased in minutes per contact ( $r = 0.30$ ;  $z = -0.889$ ;  $p = 0.37$ ). Upon further analysis, the longer

duration could be distinguished in (a) low-intensive outpatient contacts of equal length as before; and (b) high-intensive outpatient contacts of longer length but lower frequency. According to Cohen's classification, these effect sizes are small (0.2) to moderate (0.5). Inpatient admissions took place, according to the intervention, more often ( $r = 0.37$ ;  $z = -1.232$ ;  $p = 0.21$ ) but were shorter ( $r = 0.40$ ;  $z = -1.332$ ;  $p = 0.18$ ), resulting in fewer inpatient days ( $r = 0.19$ ;  $z = -0.623$ ;  $p = 0.53$ ). These results are not statistically significant but do indicate that the preventive admission schedule is followed and that it results in a slight decrease of services use, even though this was not the primary goal of the intervention. The overall rating of the degree of agreement over treatment strongly increased ( $r = 0.79$ ;  $z = -2.375$ ;  $p = 0.018$ ) from a median score of 3 to 6.

The results of the qualitative interviews with patients ( $n = 8$ ) are summarized in Figure 1. All patients value the peace and quiet that an admission brings. They do not literally say that the admission

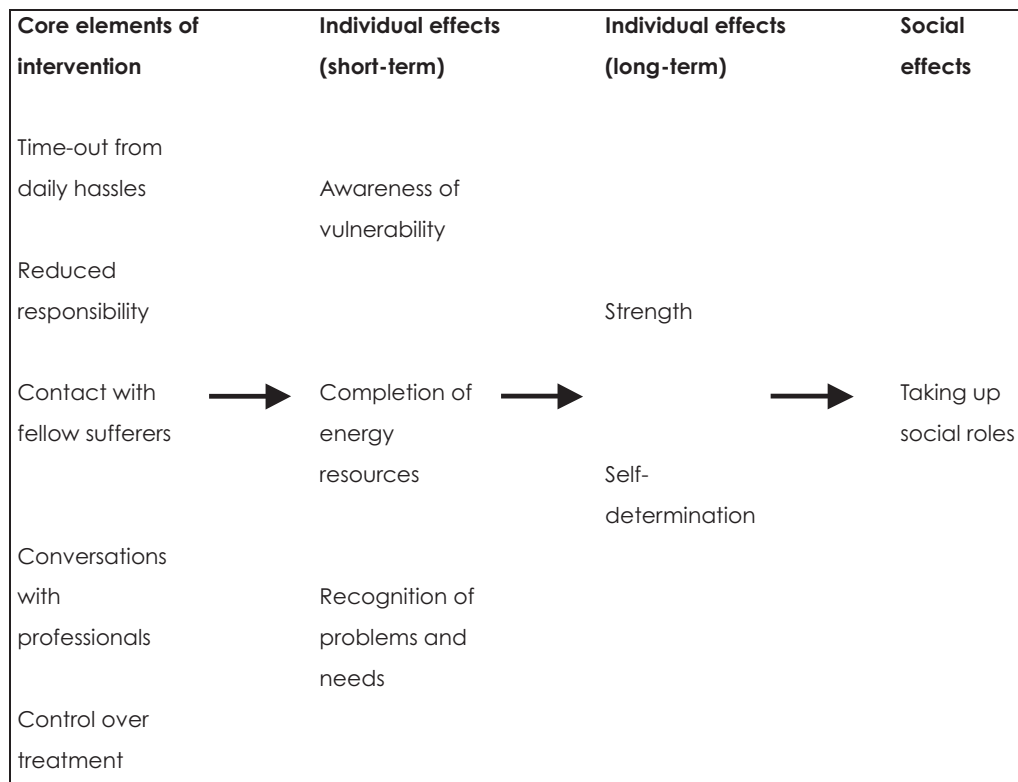
**Table 1. Effects of Preventive Psychiatric Admissions on Service Use of Participants**

Type of care		<i>Mdn</i>	<i>M</i>	Range	<i>z</i>	<i>p</i>	<i>r</i>
Outpatient ( $n = 9^a$ )							
Number of contacts	pre	17	20.8 (11.4)	10–40	-1.188	0.24	0.40
	post	15	16.3 (8.8)	7–33			
Total minutes	pre	825	1,025 (587)	430–2,060	-1.125	0.26	0.38
	post	685	778 (393)	335–1,600			
Minutes per contact	pre	36	63.4 (30.1)	36–128	-0.889	0.37	0.30
	post	43	80.7 (44.1)	43–172			
Inpatient ( $n = 11$ )							
Number of admissions	pre	3	4.1 (2.7)	0–7	-1.232	0.22	0.37
	post	6	5.4 (2.4)	2–11			
Total days	pre	30	41.8 (45.0)	0–138	-0.623	0.53	0.19
	post	27	29.5 (21.4)	12–189			
Days per admission	pre	5	9.7 (8.7)	0–26	-1.332	0.18	0.40
	post	5	5.5 (1.8)	4–8			
Degree of agreement over treatment ( $n = 9^b$ )							
Rating	pre	3	3.8 (1.9)	1–6	-2.375	0.02	0.79
	post	6	6.2 (0.6)	5–7			

<sup>a</sup>Due to unreliable service use records, data of two participants could not be included.

<sup>b</sup>Due to a change of key clinician, post-intervention data of two participants could not be obtained.

**Figure 1. Summarized Results of Qualitative Interviews With Participants (n = 8)**



ward is a peaceful place (which they say it is often not) but that it is a space where they can take time off from their daily problems and responsibilities. The regular admissions also allow them to truly relax, as one of the participants stated, "It is really, pff, nothing. You don't have to smile, don't have to laugh, you don't have to talk, you don't have to participate in anything, and if you want to go to bed early you just do so." For all, the admission is a way to refuel their energy resources. While admitted, the easy accessibility of professionals is helpful, although the lack of time and attention is criticized by many. At the same time, contact with fellow BPD patients is considered crucial for the success of preventive admissions, contributing to emo-

tional support that is hard to find in non-BPD patients, "It felt very good to know that I was not alone. It helped me to discuss my problems more easily." Moreover, contact with fellow BPD patients and staff increases participants' self-awareness of their vulnerabilities. The confrontation with acutely admitted patients with differing forms of disruptive behavior, however, is considered a negative side-effect of the preventive admission.

Another important positive element is the control participants have over their own treatment, since the preventive admission (and the preceding negotiation with the treating professional over this intervention in general) is often the first experience with a needs-

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based approach. Even though it is still highly structured, participants do perceive it as under their own control, "Because when I say I don't want to, I don't go. Then it is over, period." Some state that the behaviors seen as typical "borderline," are prevented. "It is very important that I feel listened to. If not, I become very cross and start to cause conflicts." These elements together contribute to the participants' feelings that their problems and needs are recognized through the use of the intervention. Although some have difficulties in picking up their daily routine upon discharge, most do not, "You can see it coming in time and you don't have to work so hard to recover from a full-blown crisis." When at home, the foresight of being re-admitted within a few weeks facilitates participants to deal with a crisis, "For me it helped to know that I would go again in 4 weeks. You then tell yourself, 'Hold on, hold on, only one week still to go.' I then could postpone an admission."

Thus contributing to a sense of strength and self-determination, some participants claim to be able to take up more social roles due to the intervention, "The lows are not as low, owing to the preventive admissions. Now it is more steady than just all these highs and lows." Since preventive admissions can be planned ahead, they allow participants (and their families) to deal better with their absences. Family support also facilitates participants to stay in the program, "When I don't feel like being admitted and ask my husband how to get away from it, he just says that there is no point and that I will go anyway."

### Discussion

This exploratory research shows that preventive psychiatric admissions indeed appear to facilitate treatment: It increases the rate of agreement between patient and professional, decreases crisis and long-term hospitalizations, and increases the duration, but not the frequency, of outpatient contacts. Although not aimed for, there is an overall clinically relevant decrease in service use, both in highly costly inpatient

days and outpatient contacts. However, the changes in services use are not statistically significant. The increase of the rate of agreement was significant. The individual interviews showed that patients are positive about the intervention and, maybe more important, the interviews explain some of the contributing factors.

This pilot study suffers from some limitations, a small sample size being one of the more obvious. The period in which data for each participant was collected is quite short as a consequence of the naturalistic circumstances of this study. Furthermore, the retrospective design introduces both selection and information bias. Selection bias appears because only patients who gave their informed consent after or during the intervention are included in this research. It is likely that patients who were not content with the intervention, or did not profit from it, did not participate. Information bias, in the form of recall bias, must be taken into account when interpreting the qualitative results. Retrospective rating of the agreement before the intervention is fraught with difficulties, which could include both over- and underestimation of it. To a lesser extent, this is also relevant for the qualitative interviews in which the situation before the intervention could potentially be described in light of the present context. The causal relations implied by patients' narratives and the arrow in Figure 1, although suggested by participants themselves, must thus be interpreted cautiously.

Most limitations result from the small sample size and the retrospective design in a general non-research setting. The former, however, fitted the level of development of the intervention. The latter improved the generalizability to general mental healthcare settings. Moreover, the intervention is relatively easy to carry out, little changes have to be made to current logistics or staff training levels and there are (at least theoretically) no limitations to the number of participants. It can be offered to only one patient and, depending on the presence and availability of inpatient beds, as many patients as necessary. It does not necessitate implementation of an entire treatment program or philosophy; it only requires a shared view on admissions by both

outpatient and inpatient staff (often difficult enough in itself) and clear procedures to avoid miscommunication and subsequent discontent.

The nature of the healthcare system this intervention was developed in needs to be taken into account. Dutch health care is paid for by a combination of personal insurance fees (for insurable risks such as surgery), collective fees (for so-called uninsurable risks such as life-long nursing care), and co-payments (e.g., for certain medication and psychotherapy). Current treatment and insurance guidelines prefer short in-patient admissions of BPD patients but do not put prearranged limits on the length of admissions. Even though many psychiatric professionals oppose admission of BPD patients, it is widely understood that simply refusing access to these patients increases the problems and the service use elsewhere in the healthcare system. Due to the interconnectedness of many inpatient and outpatient services and the preparedness of insurers to finance care for BPD patients, professionals may be more inclined to look for solutions that work for both the patient and the healthcare system, not just their own service.

### Implications for Nursing Practice

Preventive psychiatric admission may be an easy-to-use alternative for patients with BPD who use (inpatient) psychiatric services intensively. It may decrease the negative emotions that psychiatric nurses often have toward patients with borderline personality disorders, especially toward hospitalized patients. This pilot study, notwithstanding its methodological limitations, indicated that it may be cost effective and patient-friendly. Its lack of technical difficulty and easy applicability for patients who do not easily enroll in treatment, make it especially relevant to settings currently not well equipped to care for these often-difficult patients. However, before wider implementation is recommended, prospective and controlled research needs to be undertaken. Professional and ethical objections have thus far prevented the real-

ization of research designs establishing the usefulness of psychiatric hospitalization for BPD patients. This intervention, however, may well be tested in an experimental design without falling short in patient care.

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