The action/consequences model revisited: ethical approaches to risk for people diagnosed with 'personality disorder'

Health Improvement Scotland Webinar

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Aims

- To contextualise ethics and risk in the care of people diagnosed with ‘personality disorder’
- To introduce the action/consequences model as a tool to aid critical thinking
- Aspects of the model illustrated using theory and qualitative data around crisis care (Warrender 2024)

‘Personality disorder’

- Inverted commas to acknowledge significant debate and disagreement around the use of this label
- Insulting to some, and associated with stigma
- Multiple comorbidities, and a person with ‘personality disorder’ as their sole diagnosis is rare
- Difficulties better explained as trauma responses or neurodiversity???
- Scientific, sociological, philosophical and pragmatic debates rage on around the concept of ‘personality disorder’

- **What we do (probably) agree on – a group of people who may be emotionally overwhelmed, find interpersonal relationships difficult, be impulsive, and may recurrently harm themselves and attempt suicide**

Healthcare ethics (Varkey 2021)

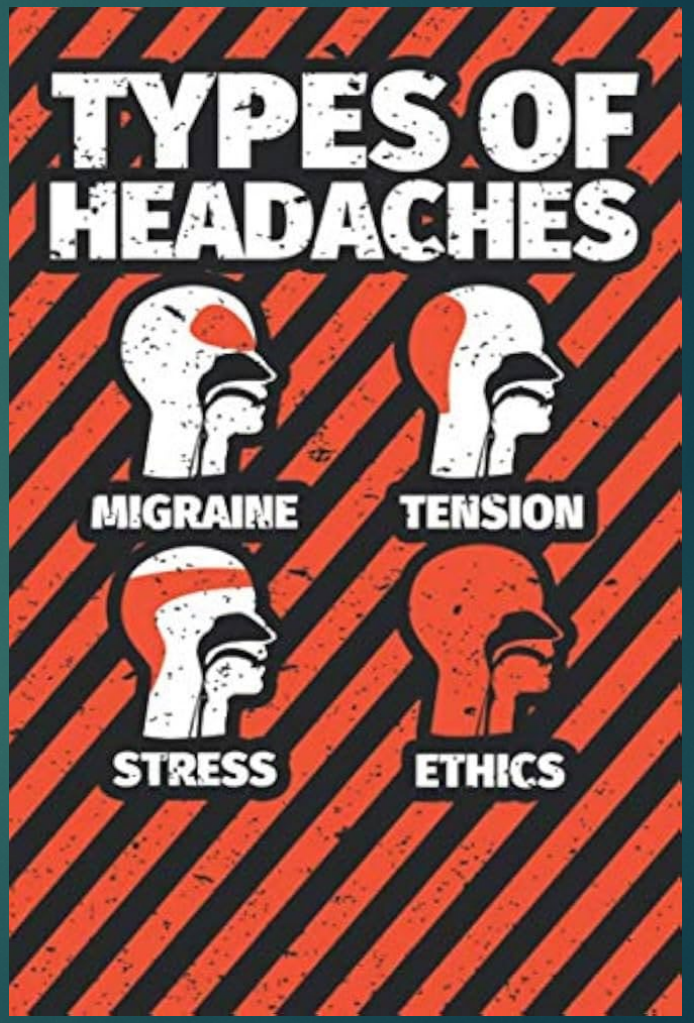
- **Beneficence**
  - Acting for the benefit of the patient. Protecting and defending their rights. Positive requirements, not just avoiding harm.
- **Non-maleficence**
  - Obligation not to harm patients. Weigh benefits against costs of interventions, and choosing best course of action. If there are harms from interventions, benefits must outweigh harms.
- **Autonomy**
  - Allowing a person to self-determine what happens to them. Weighed against competing moral principles. Autonomy does not extend to those who are deemed not to have capacity to make autonomous decisions.
- **Justice**
  - Fair, equitable and appropriate treatment of people. Are healthcare resources distributed fairly.

Ethical philosophies

(Stanford Encyclopedia of philosophy 2024)

Ethical philosophies guide what we ought to do, or what we consider right and wrong.

- **Deontology**
  - Moral duty, a system of rules. Theory which assumes choices can be morally required, forbidden, or permitted. Opposed to consequentialism.
- **Virtue ethics**
  - Emphasizes moral character. Virtues are excellent traits of character. Person based rather than action based. A person living the virtues, for the virtue's sake, not for some other reason.
- **Consequentialism**
  - Choices, acts or intentions are to be morally assessed on the states of affairs they bring about. The moral worth of an action lays in its consequences.



Risk (Fischhoff and Kadvany, 2011, Warrender and Young 2024)

- Risk is a chance of losing something of value, and people may value different things
- Risk can appear in many forms
- It may involve one event or repeated events
- It may be imposed on a person or arise from their own actions
- It can have immediate or delayed effects
- It may impact a person directly or indirectly
- Impacts may be material or psychological
- Outcomes may be certain or uncertain.

Reflection point: think about some things which you value more than others.

Goldilocks ('Just right') interventions

Approaches to people in crisis have been known to range between two extremes

- Too cold:
  - Exclusion from services, "we don't admit them", "it's their responsibility"
- Too hot:
  - Risk aversion, "it's our responsibility as you can't keep yourself safe", defensive psychiatry

To be person-centred and get it 'just right', this requires careful thought

The action/consequences model

(Warrender 2018, 2023, Warrender and Young 2024)

- A model to aid critical thinking and decision making where risk is a concern
  - Used by clinical teams in UK to aid case discussions and in quality improvement projects
  - Model yet to be 'evidence-based' but it is 'based in evidence'
- Asking questions and provoking thought based on consequentialist ethics, and whether there is help or harm
- Ask what has happened, what is happening, what might happen?
  - What is going on here?
  - Are we helping, or is this being unhelpful and harmful?
  - What might we consider doing differently?

Being honest about limitations

- *"All models are wrong, but some are useful"* (Box and Draper 1987 p.424)
- *"A map is not the territory"* (Korzybski 1931, p.750).

- This is not a 'how to' – humans are too complicated, and there are too many variables
- It is a guided discussion or reflection tool for the whole multidisciplinary team
- There will ALWAYS be dynamics not accounted for by this model, because working with risk happens in the context of human relationships.

Actions ↓	Potential Consequences →				
	Benefits	Dangers	Short term	Long term	Interpretation of motive
Containing risk	Persons safety	Retraumatisation Disempowerment	Person safety Clinician comfort	Clinician comfort Creating dependence Alienation Evolution of risk	Care and compassion Punitive control
Tolerating risk	Persons Autonomy	Retraumatisation Invalidation Clinician complacency Significant and lasting harm	Short term risk Clinician anxiety	Clinician anxiety Opportunity for person to develop own coping mechanisms	Neglect Trust and freedom

(Warrender 2018, 2023, Warrender and Young 2024)

Containing Risk vs Tolerating Risk

- Containment may include use of chemical restraint, legislation e.g. mental health act, use of observations or continuous interventions, physical restraint and seclusion.
- At its extreme a person may be detained under the mental health act, hospitalized, on continuous intervention / observation, medicated and restrained.
- **Also, importantly, containment can happen through relationships!**

- Tolerating risk includes accepting that some risk is inevitable, and risk can never be fully eliminated.
- It is an active stance, considering the benefit of tolerating risk which may benefit the person.
- At its extreme, tolerating risk sees a person having full autonomy with no input from services.

The crux of the issue: tolerating too much, or containing too much?

- *"That time last year was the first time in years that I'd been like, take me into hospital…. I was like begging them to keep me and they wouldn't keep me" (p.130)*

- *"Whereas… other times they take you in and you think that's not what I need" (p.130)*

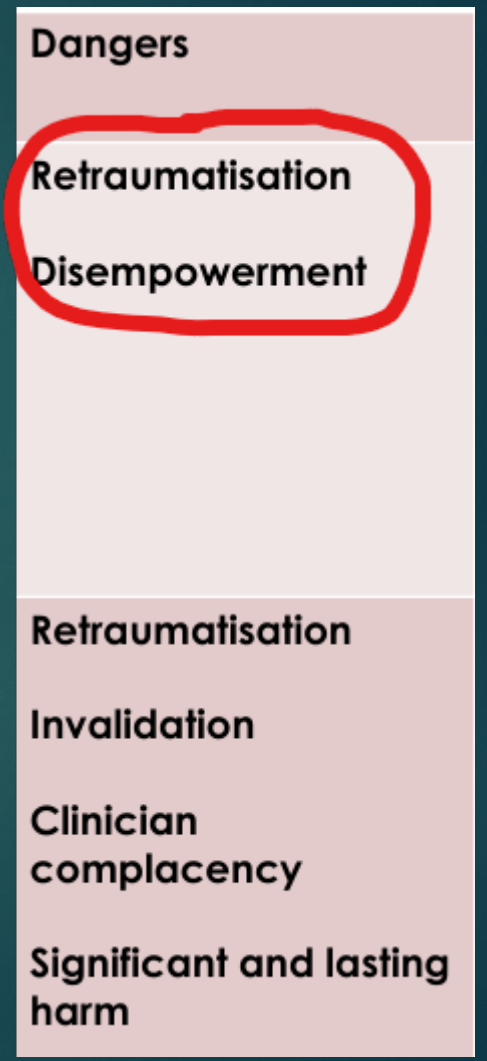
Benefits

Each approach can be justified as ethical

- **Containing risk:**
  - Consequences of not containing risk may include significant and lasting harm
  - A person's physical safety may depend on a containing intervention
- **Tolerating risk:**
  - Promotes human rights and ethical principle of autonomy
  - Least restrictive

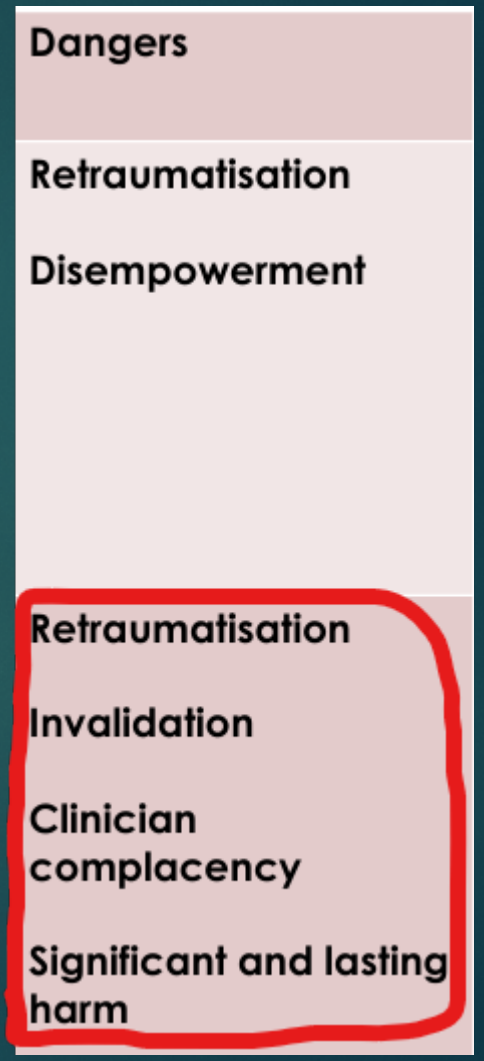
Dangers of containing risk

- **Retraumatisation:**
  - Ask: does 'safety' *feel* safe to the person?
  - "I'd be like grabbed and manhandled by multiple people… being restrained and bound is traumatizing… people pinning you down" (p.133)
  - "It was definitely… going too far... it seems very extreme… I think's caused more trauma than was helpful at the time" (p.133)
  - "It took me quite some time to get over what I'd been through in there, let alone going over why you were in there… it was sort of two recoveries at once." (p.130)
- **Disempowerment:**
  - "There's something about just being in hospital and being cut off from your usual coping strategies and things… in the sense that if someone's locked the door and said, I'm not allowed out, then I can't go for a walk, and actually, going for a walk's really good for me to regulate my mood and stuff" (p.133)
  - "But also in more negative coping strategies, in terms of self-harm and things, it's very much, come into hospital and you're not allowed to hurt yourself anymore. But we didn't actually mind if you were hurting yourself at home, like that was fine" (p.133)



Dangers of tolerating risk

- **Retraumatisation and invalidation:**
  - "I was like begging them to keep me and they wouldn't keep me" (p.126)
  - CMHN: care would have helped "had the response been healing, had it been the opposite of her childhood… but unfortunately, it was the same. It was still a little girl crying in a room and banging her head… and it just being annoying" (p.129)
  - "It's just that repeatedly in life and then… when you get poor care… you think, am I wrong? Is it me?" (p.129)
- **Clinician complacency and significant and lasting harm:**
  - "The only thing that I can control is (self-harm and attempting suicide), but sometimes… it can also be out of control as well, which is the scary part" (p.108)
  - Multiple public reports and inquests of people dying with missed opportunities to help them



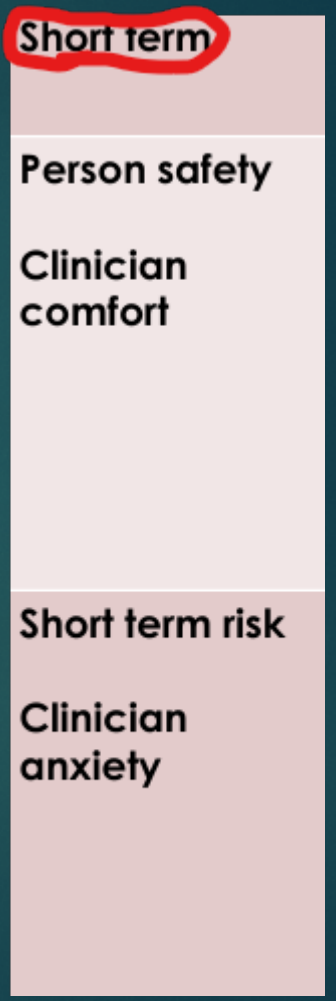
Short-term

'Safety' and comfort, or risk and anxiety?

- Episodic acute suicidality distinguished from baseline suicidality (Bateman and Krawitz 2013)
- Acute risk distinguished from long-term risk (NICE 2009)

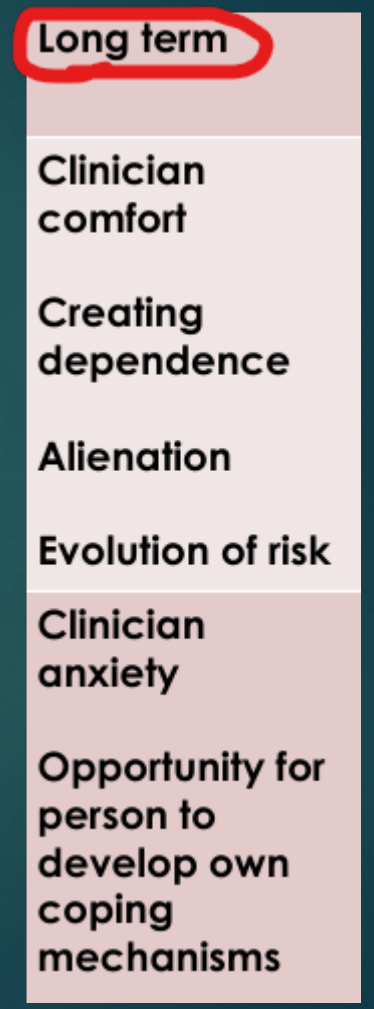
- Professional comfort vs anxiety (CMHNs):
  - "I think managing and holding risk, high risk cases, is a frightening thing" (p.117)
  - "Is it worth putting my reg on the line to take this gamble, cause it is a gamble always". (p.117)
  - "We live in a blame culture, and we are sitting ducks". (p.117)

- Containing risk in the short-term may keep a person safe
- Tolerating risk in the short-term may promote a person's long-term independence



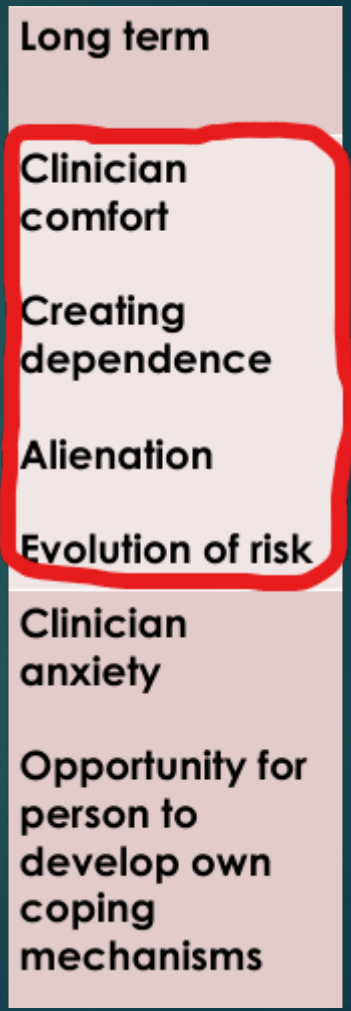
Long-term

- Crisis intervention is defined as: "an immediate response by one or more individuals to the acute distress experienced by another individual, which is designed to ensure safety and recovery and lasts no longer than one month" (Borschmann et al., 2012, p. 2).
- Beyond one-month, we enter different territory
- NICE (2009, p.320): "while risks to self and others must not be dismissed, it is also important to distinguish between long-term risks and acute ones. Failure to do so can lead to an exaggerated and inappropriate response to long-term risks".
- There can be no recovery without tolerating some risk
- Containment is *not* treatment!
  - Person agreed hospital admission was "to make sure you're safe rather than treating you". (p.129)
  - People can be kept alive, but experience social death: person loses social identity and social connectedness



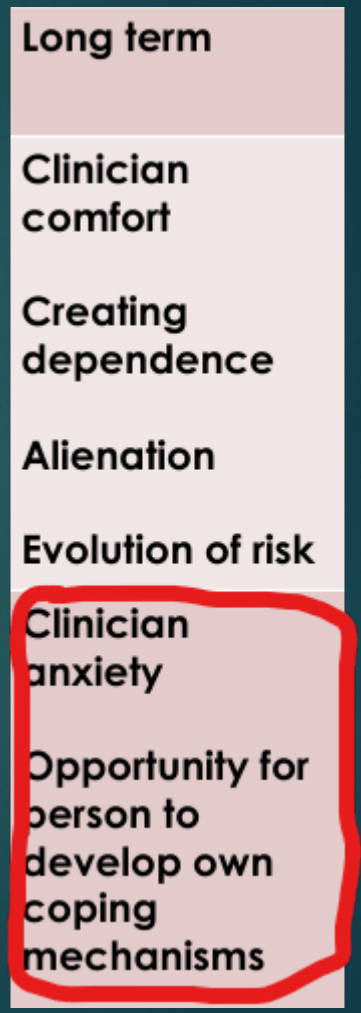
Containing risk long-term

- **Creating dependence through risk aversion and clinician anxiety**
  - Psychologist noted "I was like having to rehabilitate people who have, diagnosed BPD, but have been living in a hospital for four years because people are so risk averse... and so afraid of kind of what they would do to themselves" (p.118)
  - My hot take – *shouldn't* depend on physical interventions forever, but *should* be able to depend on relationships with staff. E.g. paradox of attachment, that dependence fosters independence
- **Alienation:**
  - "I felt like they couldn't stand me… all the other staff in the ward, I felt like they genuinely hate me. It's just a horrible feeling to have from people that are supposed to be helping you… that sense that everybody hates you all the time that you get from too many people in services is just counterproductive" (p.128)
  - Malignant alienation (Watts and Morgan 1994)
- **Evolution of risk:**
  - "Being cooped up all the time actually sends me the other way…this frustration… violence towards myself… aggression and stuff… it builds up because I have no way of like expelling my energy" (p.132)
  - Risk isn't eliminated. It changes.
  - Malignant regression (Dawson and McMillan 1993)



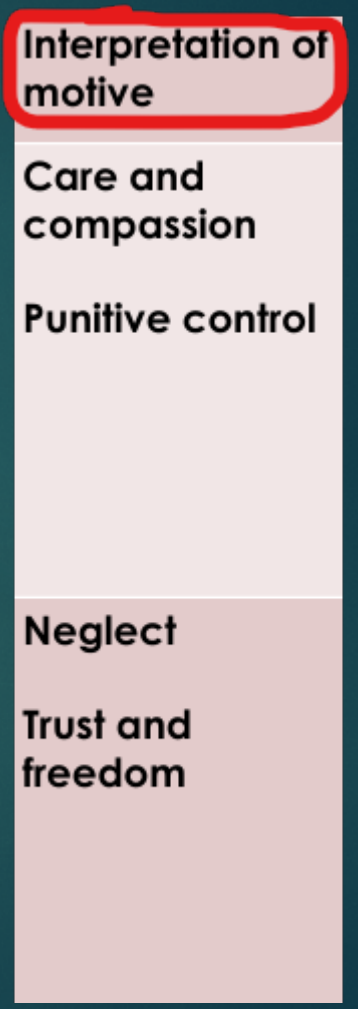
Tolerating risk long-term

- Anxiety remains: CMHN - "it is a gamble always" (p.117)
- Opportunity for person to develop own coping mechanisms
  - **BUT…** this will not happen miraculously by tolerating risk, and **WILL** require additional but more focused intervention
  - Person discussed with MH team: "they were just like… you're too unstable for therapy right now. I'm like, well, if I'd had therapy before I probably wouldn't have got that unstable… my CPNS like… you just need like three months of stability, and then we can re-refer you… but how do I get stable for three months without any help… that makes no sense to me because… the whole time with my team, they've been like… it sounds like you need therapy" (p.122)
  - Person felt the ethos was "the only thing that's gonna work for you is therapy, but we're not gonna give you therapy because you can't stop self-harming". (p.122)



Interpretation of motive

- **Not just what professionals do, but:**
  - How do they communicate what they do?
  - How do people* understand what they do?
  - How do people's* potential understandings/misunderstandings influence decision making?
  - **People can include patients, families, colleagues, professional bodies, other services and agencies, organization, media etc*
- **Key concepts: mentalization, empathy, transparency, use of self**
  - What do people think, that I think and feel? What do I think, that others think and feel? – can we make this transparent and clear, avoiding confusion and misunderstanding?
- **Potential understandings of approaches to risk:**
  - "I think that there is some level of having my control taken away, especially cause… I wasn't rational, I wasn't in my right mindset. But there was times where… it was definitely… going too far..." (p.133)
  - "It's quicker just to restrain you than it is to listen to you" (p.134)
  - "They would rather chop their own arm off than admit a person with EUPD in the middle of the night" (p.126)



Iatrogenic harm (Warrender and Young 2024, p.197)

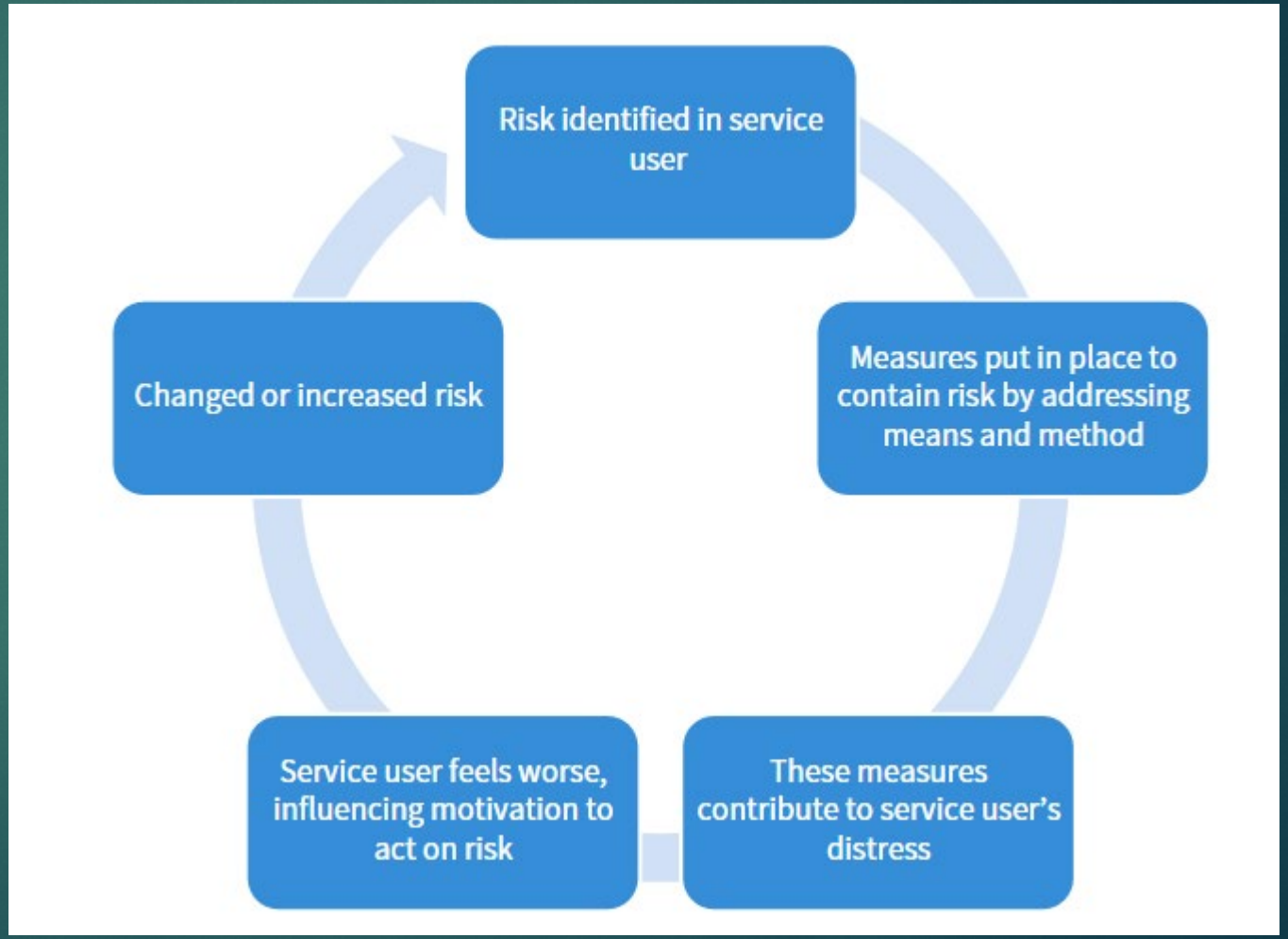
- *"It is important to be aware that risk does not just exist within the service user, and also comes from measures used by MH nurses to manage risk. It is common for MH practitioners to see themselves as heroes. Imagine firefighters coming to the rescue, pulling victims from the flames of their inner turmoil just in the nick of time. Who cares about a bit of water damage if you have just saved someone's life?"*
- *"Iatrogenic harm, like water damage, is defined as 'inadvertent' injury caused to service users by well-meaning care".*
- *"It was sort of two recoveries at once" (p.130)*

Note: iatrogenic harm may occur not just through physical restraint and removal of human rights, but by more subtle means, such as poor interpersonal skills by nurses, invalidation etc.

Iatrogenic Cycle of Containing Risk

(Warrender and Young 2024, p.200)

- *Professionals can make it worse, and become stuck in a cycle of self-defeating 'risk-management', which adds to rather than alleviates risk*
- *Person felt MH services "often increase the risk by the atmosphere of the hospital and the reactions that people get" (p.136)*



Jelly in your hands (Warrender and Young 2024, p.202)

- *"Risk can never be completely eliminated, only changed. If a service user is contained in the long term with increasing restriction, risk will simply evolve. Using an analogy, if you hold a piece of jelly in your hand, close your hand, and try to contain it more and more, no matter how hard you press, it will gradually flow outside your hand and through your fingers"*
- *"In the same way, if a person is distressed and contained more and more, removal of means and method (of enacting risk) may simply force a person to reconsider means and method. Containing risk in of itself is not treatment, and therapeutic responses need to address underlying distress"*

Containing risk through a relationship

- **Containment is defined and enacted in different ways:**
  - Dictionary: "the act, process, or means of keeping something within limits"
  - "Containment may be physical, chemical, or legal, and examples may range between hospital admission, use of medication, the Mental Health Act, and physical restraints". (Warrender and Young 2024, p.201).
  - Emotional containment: "Holding and containing involves a capacity to do nothing, 'to be with' the patient" (Bateman, Brown and Pedder, 2010, p.117)
  - Crisis care often responds to behaviour (e.g self-harm or suicide attempts) but does not address underlying distress (Warrender et al 2021)
- **Sharing risk:**
  - "Being with" without the need to fix the problem
  - Being transparent with your mental state and what you are thinking, and why you make decisions
  - Empathy and "understanding as an intervention" (p.145)
  - Being least restrictive, genuinely collaborating on decision making, including family if agreeable

The action/consequences model:

- Warrender, D. (2018). Borderline personality disorder and the ethics of risk management: the action/consequences model. Nursing Ethics 25(7), 918–927. Available: https://journals.sagepub.com/doi/10.1177/0969733016679467
- Warrender, D. (2023). Poster: The Action/Consequences Model - a tool to prompt thinking and ethical decision making around risk. In: Proceedings of the British and Irish Group for the Study of Personality Disorder Conference. 13th-15th June. Radisson Blu Hotel, Glasgow: British and Irish Group for the Study of Personality Disorder. Available: https://www.researchgate.net/publication/371038224_The_ActionConsequences_Model_a_tool_to_prompt_thinking_and_ethical_decision_making_around_risk
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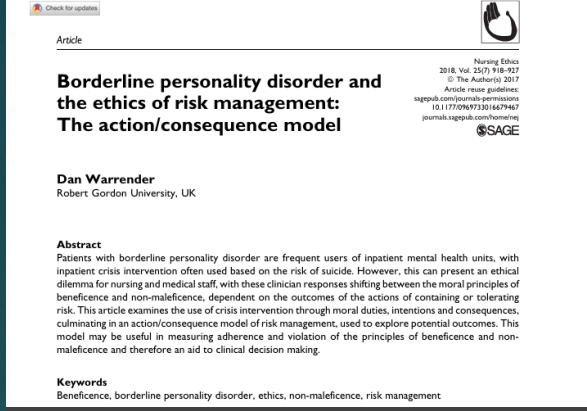

Article

Borderline personality disorder and the ethics of risk management: The action/consequence model

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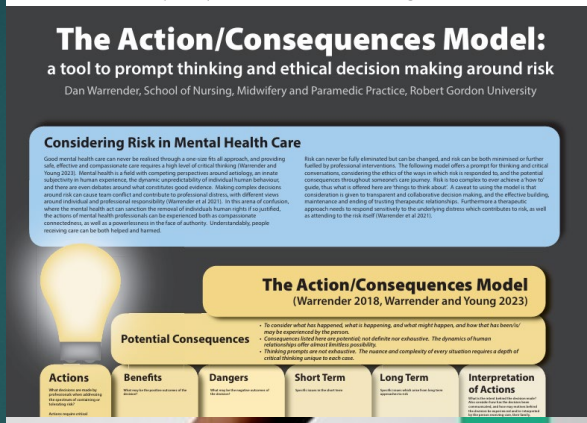
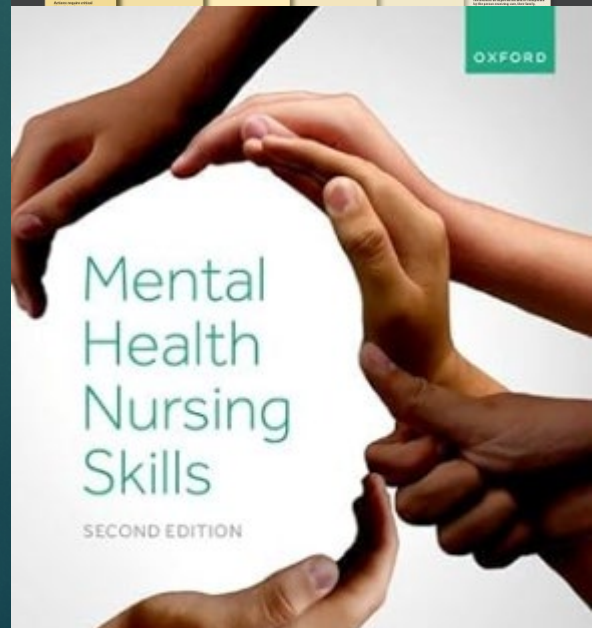
Abstract
Patients with borderline personality disorder are frequent users of inpatient mental health units, with inpatient crisis intervention often used based on the risk of suicide. However, this can present an ethical dilemma for nursing and medical staff, with these clinician responses shifting between the moral principles of beneficence and non-maleficence, dependent on the outcomes of the actions of containing or tolerating risk. This article examines the use of crisis intervention through moral duties, intentions and consequences, culminating in an action/consequence model of risk management, used to explore potential outcomes. This model may be useful in measuring adherence and violation of the principles of beneficence and non-maleficence and therefore an aid to clinical decision making.

Keywords
Beneficence, borderline personality disorder, ethics, non-maleficence, risk management





Further resources:

- Dan Warrender - a critical introduction to 'borderline personality disorder' - NIP Conference 2020 https://www.youtube.com/watch?v=4lx8VGDkbwE&t=113s
- Warrender, D. 2024. A "fireball of emotion": a qualitative case study exploring the experiences of crisis and crisis intervention for people diagnosed with 'borderline personality disorder', their family and friends, and professionals who work with them. [PhD thesis, Robert Gordon University]. Available from: https://www.researchgate.net/publication/384444612_A_fireball_of_emotion_a_qualitative_case_study_exploring_the_experiences_of_crisis_and_crisis_intervention_for_people_diagnosed_with_'borderline_personality_disorder'_their_family_and_friends_and_prof
- Dan Warrender - PhD Thesis Presentation 2024 - Crisis intervention for people diagnosed with 'BPD' https://youtu.be/WnjfFfItGnQ

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