Crossing borders: theory, assessment and treatment in borderline personality disorder

CHAPTER 9

Summary and General Discussion

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This thesis started with an overview of the current state of affairs in our knowledge of borderline personality disorder (BPD) with respect to its conceptualization, patient characteristics, etiology, assessment and (experimental) treatments. Within these domains, different empirical research issues were defined and tested in the studies presented. This chapter will give a summary of the findings, followed by a general discussion; including implications for clinical practice, as well as directions for future research.

Summary of study conclusions

Part II *Chapter 2* It was tested whether BPD is characterized by specific world views as hypothesized by cognitive models, using Janoff-Bulman (1989) world assumptive model of negative effects of trauma. A second aim of this study was to investigate the role of trauma in the content of world views of BPD patients. The cognitive theory's central assumptions for BPD (the world is (i.e. others are) dangerous and malevolent; I am powerless and vulnerable; and I am inherently unacceptable) were to a large extent supported by using Janoff-Bulman's theoretical framework of world assumptions (Janoff-Bulman, 1989). The content of world assumptions of BPD-patients could better be explained by BPD-specific pathology than by presence and severity of childhood trauma.

Chapter 3 In this chapter the psychometric properties of the 48-item Defense Style Questionnaire (DSQ-48) were investigated. Other aims of the DSQ-48 study were to replicate the three-factor structure of the DSQ-36 (Spinhoven, van Gaalen*, et al.*, 1995) and to compare the defensive style of different patient and non-patient groups. With respect to the presence and role of defense mechanisms, as defined by the psychoanalytical object-relation theory, BPD-patients can indeed be characterized by the use of primitive defense mechanisms as assessed with the DSQ-48 (and the IPO-borderline organization structure), and can be distinguished from other patient and non-patient groups. The psychometric evaluation revealed some shortcomings, eventually leading to an alternative 5-factor structure (distrust, self-protection, self-sacrifice, avoidance and control) with better psychometric properties. Forty-three of the 48 DSQ-items were included.

Part III *Chapter 4 and 5* The studies in these chapters examined the assessment and conceptualization of borderline personality disorder with the 'BPDSI-IV' semi-structured interview and the Borderline Personality Disorder Checklist (BPD Checklist) self-report questionnaire. The BPDSI-IV assesses the severity and frequency of BPD-pathology in detail, the BPD-Checklist assesses

the burden experienced from BPD-pathology. Both instruments proved to be psychometrically sound by having good internal consistencies, and good discriminant, concurrent and construct validity. Clinical norms, specificity and sensitivity were derived for clinical and research applications. The BPD Checklist further revealed sensitivity to change, and the same applied to the BPDSI-IV which was most specifically shown in Chapter 6. The second research aim involving the BPD Checklist and BPDSI-IV led to the conclusion that, by using the items of either instruments, both a one- and a nine dimensional model based on DSM-IV BPD-criteria have empirical validity. The validity of these one- and nine factor dimensional models was better than of three- or four higher order factor models as suggested in previous research.

Part IV *Chapter 6 and 7* The effectiveness of three years of Schema Focused Therapy (SFT) and Transference Focused Psychotherapy (TFP) was investigated in a multicenter randomized controlled two group design. Maintenance of the results was examined after a 1-year follow-up period. Three years of twice weekly SFT and TFP proved to be effective in reducing borderline specific psychopathology, general psychopathology and measures of SFT/TFP concepts, and in improving quality of life. After three years, SFT was more effective than TFP on all measures. One-year follow-up results continue to show a positive treatment perspective for BPD, as more BPD-patients achieved recovery and/or reliably changed status than after 3 years. At year 4, SFT remained favorable over TFP with regard to reduction in BPD-pathology, general psychopathology and measures of SFT/TFP concepts. SFT and TFP were equal effective for quality of life at 1-year follow-up.

Chapter 8 The quality and development of the therapeutic alliance as a mediator of change in SFT and TFP was studied. Therapeutic alliance scores were higher in SFT than in TFP. Negative ratings of therapists and patients at early treatment were predictive of dropout, while increasingly positive ratings of patients in the first half of treatment predicted subsequent symptom reduction. Dissimilarity between therapist and patients in pathological personality characteristics had a direct effect on the growth of the therapeutic alliance, but was unrelated to outcome. Based on these findings, it was concluded that the therapeutic alliance is an important common therapy factor critically affected by type of treatment.

Overall it can be concluded that borders have been crossed in borderline personality disorder research. A first border concerned testing (parts of) two psychological models of BPD by using different, cognate psychological theories; Beck's cognitive BPD core assumptions were tested by Janoff-Bulman's social cognitive world assumptions; defensive styles were tested against object-relation

based primitive defenses and cognitive based coping mechanisms. A second border involved the development of reliable, valid and change-sensitive assessment instruments (the BPDSI-IV and the BPD Checklist), specifically designed for BPD-pathology in screening- and treatment outcome procedures. This includes the different self-report and semi-structured interview formats, even enabling both subjective and objective BPD-pathology assessments. A third border crossed is the successful enterprise of executing a prolonged well-designed randomized clinical multicenter trial of outpatient treatments for borderline patients (Schema Focused Therapy versus Transference Focused Therapy). Moreover, this randomized trial (RT) empirically supports a changing perspective on BPD-treatment: from untreatable to treatable. Finally, the fourth border passed, relates to the unique collaboration of two different psychological treatment formats in one trial.

Discussion of the borderline treatment study

Many psychological theories and (manual-based) treatments have been developed over the last two decades (see chapters 5 and 6 for references). As a result, the opinions on the possibilities of treating BPD have fortunately become more optimistic. However, research to provide an empirical basis for BPD-specific theories and treatments is still lagging behind. A major aim of this thesis was to contribute to the empirical knowledge by evaluating two relatively new outpatient BPD-treatments. This paragraph will discuss the methodological strengths and weaknesses.

A first strength of this Borderline treatment study is that all participants were screened with optimal diagnostic procedures (Zimmerman, 1994; Zimmerman & Mattia, 1999a; b), using DSM-IV based semi-structured clinical interviews (SCID-I and –II) that have proven to reliably and validly assess the DSM-IV Axis-I and –II disorders (First, Gibbon*, et al.*, 1997; First, Spitzer*, et al.*, 1996; Groenestijn, Akkerhuis*, et al.*, 1999; Weertman, Arntz*, et al.*, 2000). Second, the use of a wide, 2-month time frame for the screening procedure was valuable for several referred patients, who realized during this phase that they could and/or would not be able to meet the expected time-investment in therapy and research assessments, and therefore protected both SFT and TFP from attrition unrelated to the treatment itself. However, this wide time frame has also a negative side to it, as it resulted in a selection process among the borderline patients and therefore limits generalization. Other strengths are (3) the sample size, (4) the study's duration, (5) regular 3-monthly assessments with an additional 1-year follow-up enabling to chart progress and treatment processes in detail, (6) the wide array of assessment instruments including psychometrically sound ob-

server-rated and self-reported a-theoretical measures, theory guided instruments and process measures, (7) the participation of therapists who were trained by treatment developers dr. Young (SFT) and dr. Yeomans (TFP), (8) the use of treatment integrity procedures and (9) and the high comparability of SFT and TFP with respect to treatment intensity and treatment aim (fundamental personality change leading to full recovery).

Even though many strengths could be noted; no study is perfect, nor are study results ever totally unambiguous. As discussed in chapter 6 and 7, limitations of the present study are (1) the absence of a regular treatment-as-usual (TAU) and/or a non-treatment condition, (2) non-blindness of research assistants as the study progressed, as patients talked about their treatment and therapist and (3) non-blindness of the study psychiatrist. Besides the limitations, some observations of the BPD outcome study deserve additional attention.

A first observation is that during the study it became clear that some of the patients had comorbid disorders, which were pre-set exclusion criteria and should have been detected during the screening procedure. According to their therapists, at least three patients apparently suffered from dissociative identity disorder (DID). The current procedure included a screening step with the Dissociative Experience Scale (DES; Boon & Draijer, 1995; Draijer & Boon, 1993). If a potential participant had a total score above 25, the elaborate DSM-IV based interview for DID was administered (SCID-D; Boon & Draijer, 1995). One can wonder whether the DES-cutoff score of 25 was too high, whether the two-step screening procedure was inadequate and all patients should have been interviewed, or whether the SCID-D's properties should be questioned. When balancing methodological and feasibility aspects, the chosen screening procedure on DID still can be considered optimal. However, what becomes evident from this study's experience is that not only experienced screeners are needed but that (peer-) supervision in the screening process is advisable, as well as resistance to time-pressure (e.g. in waiting for old hospital records). As for the current study, two DID-patients were fortunately randomized to SFT, one to TFP, and this allocation more or less reduced a possible unequal influence on treatment outcome. Two other patients prematurely stopped treatment due to psychotic decompensation. Independent retrospective file-based diagnostic procedures learned that one patient was evidently wrongly included, as an earlier psychotic episode was overlooked. The other patient probably suffered from an organic psychosis. Both were allocated to the SFT condition, implying that their inclusion probably counteracted the efficacy of SFT. Still, all patients were included in the outcome analyses for two reasons. Firstly, it was pre-determined that conservative statistical procedures would be employed in order to avoid any artifacts, which means that all available 'cases' should be included. The second argument refers to the intention to study BPD-patients who are optimally representative for a regular

clinical set of BPD-patients. It was reasoned that wrongful or missed diagnoses are also part of real-life in mental health care. Thus, although it was highly undesirable for both SFT/TFP outcome results to include "false positives", the interest of external validity overruled post-hoc considerations.

A second observation concerns three patients who fell out the study during the TFP-contract phase as patient and therapist were unable to start the contract phase or reach a (verbal) contract. One can ask whether these BPD-patients should be viewed as drop-out due to unsuccessful treatment, since this pre-phase determines the framework to start actual TFP. In the view of the developers of TFP, a drop-out patient in the contract phase is protected from an ineffective (and unwanted) treatment endeavor. The contract phase aims to function as a filter, and assists optimal treatment indication. However, empirically speaking, including a statistical correction for this functional TFP-feature did not seem warranted as an exclusion from treatment in the contract phase is also an outcome. Another argument is that several studies report on attrition rates as treatment outcome in themselves (Bateman & Fonagy, 1999; Linehan, Armstrong*, et al.*, 1991), mostly because keeping borderline patients in any treatment has for long been a primary objective in itself. Therefore, reasons of drop-out (including contract phase drop-outs) are separately reported to make individual conclusions possible (Chapter 6, Figure 1).

A third remarkable observation concerns the fact that most TFP dropouts occurred during the first treatment year, whereas most SFT dropouts were counted in the study's second 1.5 year. It was a priori hypothesized that drop-outs, if any, would happen during the first year of treatment. This was based on the instability in (meaningful) relationships that many BPD-patients experience. Starting treatment for a borderline patient implies the difficult 'task' of starting a new meaningful relationship with a therapist, exposing oneself to potential risk for additional problematic experiences. This probably also explains (part of) the TFP-dropout occurrence. The differences in therapeutic role between TFP and SFT (dynamically neutral, reflective versus supportive, directive) could also be of influence. From a clinical prospect, late non-responding drop outs are most inconvenient, one wants to detect non-responsiveness (dropout) as soon as possible, 'to help as many patients with less money in less time'. The late SFT drop-out patients did not significantly improve on the primary outcome measures. In further developing SFT, specific attention should be paid to characteristics involving SFT-indication. Treatment progress monitoring can also contribute in detecting (and acting) on non-responsiveness, as studies have shown that providing feedback to therapist and patient on the patient's progress can enhance treatment outcome (Lambert, Hansen, & Finch, 2001; Lutz, Rafaeli, Howard*, et al.*, 2002). When examining the study events and results in retrospect, one should not only search for explanatory factors in different treatment characteris-

tics but also in (intertwined) therapist and patient characteristics. Paragraph 9.3 will focus on some of these characteristics.

A fourth issue of the borderline treatment study to be addressed regards the ongoing development of the SFT and TFP manuals during the study. Even though both treatment manuals appeared to be at an advanced, final state when the study started, some changes in the guidelines of both SFT and TFP were observed at national supervisions by the treatment developers dr. Young (SFT) and dr. Yeomans (TFP) over the years. An example for SFT is, what was initially called '24-hour reachability' (by telephone) of the therapist, requiring that a SFT-therapist should also be reachable to the patient outside office hours at any time. At first, this seemed a quite strict prerequisite for a therapist to participate in the treatment study. However, the clarification (and application in the Dutch mental health care tradition) of this issue took some time but made clear that a SFT-therapist has room to set personal limits with respect to availability to a patient outside office hours. For instance, a therapist can explain to the patient why he/she cannot answer the phone and discuss what in that case has to be the next step for the patient because he/she is away, on a break, asleep, etcetera. An example for TFP concerns the guidelines for deviating from a technical neutral stance. At first, active involvement of the TFP-therapist towards the patient outside therapy sessions was only very rarely allowed and if permitted, would often lead to termination of TFP and was considered as a (serious) contract breech by the patient. Later in the study, the TFP-therapist appeared to be allowed to temporarily deviate from, and then return to, neutrality more easily without necessarily losing or breaking with the TFP-treatment frame. These developments were completely natural, understandable and justifiable from a clinical perspective. However, from an efficacy research perspective these developments at that time were not welcome since a researcher wants to have clearly defined, stable interventions. Therefore, it should again be emphasized that the outcome results need balanced interpretation. The SFT- and TFP-manual in a next RT will undoubtedly be somewhat different from the SFT- and TFP-manual of the present RT.

The study results present a positive message by increasing the evidence-based treatment possibilities for BPD-patients. However, in studying long-term treatments outcome, the focus is not only effectiveness in itself, but also the relation between treatment duration and effectiveness. Justification of long-term therapy is an issue with considerable clinical (i.e. therapists case loads, waiting lists, achieving optimal improvement) and economical (i.e. health care insurance policies, governmental regulations and mental health care budget) implications. For BPD-patients it is already argued (introductory chapter) that short-term treatments are not sufficient and long-term treatments are indicated. With respect to SFT and TFP, observing the improvement patterns of successful pa-

tients, as well as identifying factors that were predictive of patient-dropout, can help to define criteria that optimize indication and justification of long-term treatment. Differences between SFT and TFP can be incorporated in these criteria, and may also contribute to a higher and more efficient treatment success/effectiveness rate for both treatments. Unfortunately, Dutch political decision-making in mental health care has a tendency to act before relevant results are available. As a result, many BPD-patients today are denied optimal recovery opportunities and what's more from a societal perspective, savings are missed (e.g. through reduced use of Disablement Insurance Act, Dutch Health Law, unemployment). This study demonstrates the short-sightedness of recent governmental policy changes with respect to the limitations on reimbursement of individual psychotherapy. The now imposed maximum of 50 therapy sessions for BPD patients is absolutely insufficient to reach recovery and/or significant improvement.

In addition to the current discussion, it must be noted that another major part of this study was assessing TFP and SFT's cost-effectiveness (van Asselt, 2006). Preliminary analyses reveal that psychotherapy (either SFT or TFP) from an economically based 'quality adjusted life year'-unit (QALY) point of view, already becomes cost-effective during treatment. In other words, although society has to invest in individual psychotherapeutic treatment, already during treatment society will receive more money back than invested, while quality of life of the patient increases. Cost-effectiveness calculation of SFT and TFP will be available soon. Other issues in BPD that were investigated with data obtained within the present trial centered around three foci: (1) relations between autobiographical memories, memory processing and childhood trauma (Kremers, 2004), and (2) relations between informational processing and cognitive and psychodynamic theories of personality disorders (Sieswerda, 2006). These (sub-) studies further illustrate the significant contribution of the present study framework to an empirical basis for understanding and treating BPD.

Patient - therapist factors in treatment outcome

With respect to patient – therapist factors, a general distinction can be made between factual variables (e.g. age, gender and other numbers) and process variables. Process variables appear more fluid and often contain an interactive component between patient and therapist, in which the 'factual' factors also play a role (e.g. patient-therapist relationship; therapists' capacity to endure aggression; patients' capacity to self-reflection). As said, the borderline treatment study also investigated determinants of the therapeutic alliance and treatment outcome (See *Chapter 8*).

Most treatment outcome studies ascribe treatment effects in patients to the investigated treatment(s), meaning the specific systematic appliance of theoretically defined treatment techniques and strategies. The influence of the relationship between patient and therapist, the therapeutic or working alliance, is also often acknowledged and considered important, see for instance *Chapter 8*. Many psychotherapeutic treatment protocols from different backgrounds (like SFT and TFP), emphasize the importance of the therapeutic alliance for optimal treatment results and include, in addition to technical and strategic aspects, specific directions to the interpersonal style a therapist should adopt in treatment. Treatment integrity checks, including the therapeutic stance, are often tailor-made to one treatment, making comparisons between therapeutic stances from different treatment perspectives problematic. Most studies focusing on the patient-therapist relationship in relation to psychotherapy outcome and drop-out, often do not report specifically on the contribution of therapist background to the patient-therapist relationship, and with that more or less implicitly assume that the therapeutic interpersonal style is not substantially different across theoretical schools (Kiesler & Watkins, 1989; Wallner Samstag, Batchelder, Muran*, et al.*, 1998). Along the ratings for the treatment integrity procedures (Chapter 6) and therapeutic alliance ratings (Chapter 8), an exploration whether this implicit assumption is accurate was undertaken. Results of this pilot study can be found in Appendix I. Chapter 8 and the pilot study show, in contrast to the referenced literature, that therapeutic alliance and therapists' interpersonal style are not a-specific, and appear related to treatment method and therefore to therapist background / theoretical schools. Moreover, alliance ratings were predictive of drop-out and treatment outcome. And although the reliability of the pilot study cannot be warranted, it is still striking that the lower affiliation scores of TFP-therapists on the Interpersonal Behavior Observation (IBO) compared to SFT-therapists are in line with the more negative alliance ratings of TFP-therapist than those of SFT-therapists. The present findings further demonstrate that treatment outcome is indeed empirically determined by both treatment method and patient-therapist relationship (including the contribution of therapist's interpersonal style). However, it will be a complicated task to clarify in future studies how and to what extent therapeutic alliance, and inherent to that, therapist's interpersonal style mediate and/or moderate treatment outcome.

The SFT- and TFP-therapist groups were similar in professional status, experience, age and personality features (Young Schema Questionnaire and the Inventory of Personality Organisation). Furthermore, gender did not prove to have a significant contribution to outcome. Still, one should realize that these factors are of influence, in most cases indirectly, on treatment outcome. For example, it will cost a relatively inexperienced therapist probably more attention and effort to adequately set limits during therapy than one of the study therapists. And it

was already observed during the study that some therapists also had difficulties with limit setting (either in SFT or TFP, and either due to individual character or treatment model interpretation). This can, in turn, increase treatment duration. It is of importance that these aspects are addressed in treatment supervision in order to ensure an optimal match of therapist and patient. An optimal match in personality dimensions was found to be of positive influence on the therapeutic alliance. However, the subsequent effect of this match on treatment outcome is negligible.

Some instability in the SFT therapist group was observed during the study period, which of course was unwanted from an empirical perspective but realistic for the clinical practice of personality disorders (thus enhancing external validity of the SFT-results). Changes in therapist availability can in part be explained by the long duration of the study. However, all switches of therapists within a treatment process in the 3-year study period remarkably happened in the SFT-group. Four SFT-patients had to switch therapists for a four month period as their own, initial therapist was on maternity leave. Another four SFT-patients had to switch due to changes in their therapists' personal life (e.g. job change, long-term sick leave). Still, how (or if) these switches have affected SFT outcome, cannot be determined, as $n = 8$ is too small for a reliable assessment.

A noteworthy patient related factor was the observation that treatment outcome was negatively influenced by use of psychotropic medication. In achieving optimal treatment indication for patients, one can wonder how use of psychotropic medication should influence the decision to offer SFT or TFP. It is no option to deny BPD-patients on psychotropic medication psychotherapeutic treatments; a substantial part of the BPD-population would then be deprived of treatment while these patients do improve, but to a lesser extent than those without psychotropic medication. Furthermore, it is not unlikely that BPD-patients on psychotropic medication form an a priori negative selection. However, it could be useful to investigate whether this subgroup of BPD-patients might benefit more from other (manual-based) BPD-treatments, especially if such a treatment would turn out to be as effective but less intensive and/or less costly. Another hypothesis to be examined, following the present observation and Simpson *et al* 's finding (2004) that single dialectical behavioral therapy (DBT) was more effective than a combination of DBT with psychotropic medication, is that treatment outcome could improve when potential SFT- (and TFP-) patients would stop or reduce psychotropic medication as much as possible before entering or during treatment. Furthermore, it is of interest to determine if different types of psychotropic medication (antidepressants versus anxiolytics versus antipsychotics) have differential effects on psychosocial treatment outcome.

Categorical and dimensional conceptualization

The debate on dimensional versus categorical conceptualizations of personality disorders is rather intense, as demonstrated by the large literature on this subject (e.g. Costa Jr. & McCrae, 1990; 1992; Frances, 1982; Livesley, Jang, & Vernon, 1998; Nelson-Gray & Farmer, 1999; Watson, Clark, & Harkness, 1994; Westen, ; Widiger & Mullins-Sweat, 2005). All patient classifications used in this thesis are based on the DSM-IV categorical approach of BPD. The DSM-IV-TR (APA, 2000) refers to the dimensional perspective as an alternative for the categorical model in which "personality disorders represent maladaptive variants of personality traits that merge imperceptibly into normality and into one another" (p.689). Most objections to the categorical conceptualization of personality disorders concern excessive diagnostic co-occurrence, heterogeneity among persons with the same diagnosis, absence of a non-arbitrary boundary with normal functioning, and inadequate coverage of maladaptive personality functioning (e.g. Widiger & Mullins-Sweat, 2005). Heterogeneity as demonstrated by comorbid disorders, was indeed observed in patient groups from different studies (*chapters 2-8*). Especially the personality disordered patients had substantial comorbid diagnoses that at times interfered with preset exclusion criteria. For example, patients qualifying for the Cluster C group were not allowed to have more than two traits of a Cluster B personality disorder (SCID-II). Several potential participants were excluded because of this, somewhat reducing the overall clinical representativeness of the Cluster C group patients.

Despite the disadvantages, there are theoretical and practical aspects that argue for a categorical model. Medicine has always approached illness descriptively and categorically. Only when personality disorders were noted and accepted as a group of mental disorders, the history of personality disorders as such started, and empirical research in this field was initiated (Paris, 1996). The literature on dimensional views of personality proves that these may theoretically be well-founded and may form an optimal base for studying regular/normal/healthy personality but that the dimensional models' relations with psychopathology is yet unclear (Watson, Clark*, et al.*, 1994). Focusing on the present clinical applications of a dimensional perspective, especially with respect to (borderline) personality pathology, problems arise. When having personality functioning represented by a single dimension, the boundary between adaptive and maladaptive personality functioning may be more accurate and complete than in a categorical classification system, but this can easily become cumbersome and impractical in clinical settings. Unlike axis-I disorders, BPD (and other PD's) cannot be shortly described. Categorical constructs (diagnostic labels) seem more accommodating and easier to use, with only one central connotation

for all constructs/personality disorders to keep in mind: differences between individuals with the same diagnosis do exist. The widespread use throughout medical and mental health care further illustrates the practical strength of categorical data. The issue of individual differences is recognized as much research within the categorical framework on the identification of (higher-order) factors within diagnoses is performed.

Two of the studies (*chapter 2* and *chapter 3*) tested possible categorical classifications within a BPD diagnosis. The similar designs of these studies only varied in the instruments by which different DSM-based categorical BPD-models were tested, which enables a highly valid comparison of the results. Both studies support the present DSM-IV BPD-concept with identical findings. Either data could be best interpreted with a one- or nine factor structure, as interpretations of three or four higher-order factors led to considerable information loss. These results argue against the 'dimensional' objection of heterogeneity as being a diagnostic limitation; individual differences still come together in one underlying perspective. On the other hand, one can view the nine separate DSM-IV criteria as a dimensional description of BPD. Adding either BPD-Checklist or BPDSI-IV to a regular categorical screening or diagnostic procedure, would be even more accommodating towards the dimensional approach, since that would chart a larger heterogeneity-part with additional unique information.

So far, the DSM-model has been largely used to illustrate the contrast of categorical versus dimensional conceptualization with regard to personality disorders. Another line of categorical classifications that are related to personality disorders finds its origin in different psychological orientations. The DSM-IV is a descriptive and a-theoretical system that, as said before, provides common ground and a common 'language' overcoming professional and theoretical differences in the clinical field. Alternatively to the DSM-IV, theory-driven classification models are likewise able to add to the dimensional – categorical debate. Relevant examples here are Beck and colleague's cognitive model of personality disorders (Beck, Freeman*, et al.*, 1990; Beck, Freeman*, et al.*, 2004) and Kernberg's psychodynamic model of personality organizations (Kernberg, 1984; Kernberg, 1996), of which borderline specific parts (BPD key assumptions of the cognitive model and BPD primitive defense mechanisms of the psychodynamic model) were subjected to empirical testing in chapters 2 and 3. As for the cognitive theory on BPD, good support was obtained for the core assumptions that are believed to be specific for BPD (Beck, Freeman*, et al.*, 1990; Beck, Freeman*, et al.*, 2004). And within another theoretical line, the DSQ-48 was able to prove that with respect to defense mechanisms BPD-patients are indeed characterized by primitive (or immature) defense mechanisms. In addition to the theoretical implications, these findings add to the validity of the SFT and TFP treatment models that were evaluated in chapter 5 and 6. With respect to the role of childhood

trauma in the etiology of BPD, correlational evidence further endorsed the cognitive perspective: not the presence of trauma determined world views (or BPD assumptions) but the way it becomes part of personality (i.c. BPD). In sum, both studies were supportive of the validity of categorical theory-driven classifications for borderline personality pathology.

Another consideration is that the dimensional model currently has hardly any treatment directions available for a patient with a dysfunctional dimensional personality profile, let alone for BPD. This is in contrast with numerous and extensive treatment directions based on categorical systems, of which Schema Focused Therapy and Transference Focused Therapy are two examples. Categories apparently are also deemed necessary within the dimensional model, at least with respect to treatment implications. 'Dimensional' suggestions have been made to retain personality disorders as lower-order (behavioral) expressions of personality traits, which would facilitate clinicians to treat symptoms, in addition to an explicit dimensional formulation of (borderline) personality and while avoiding much overlap as occurs with (DSM-IV) comorbidity (e.g Widiger & Mullins-Sweat, 2005). Other propositions to use dimensional as well as categorical models complementarily, or to attempt incorporating valuable features of both models in one general approach, have been made as well (Clarkin, Hull, Cantor*, et al.*, 1993; Paris, 1996; Saulsman & Page, 2004; Shedler & Westen, 2004; Skodol, Siever*, et al.*, 2002; Trull, Widiger*, et al.*, 2003; Westen & Shedler, 1999). Whether personality disorders should be classified categorically or dimensionally remains an empirical issue. At present, several taxometrical studies suggest a dimensional conceptualization of personality disorders over a categorical conceptualization (Ayers, 2000; Haslam, 2002; Rothschild, Cleland, Haslam*, et al.*, 2003; Simpson, 1994; Trull, Widiger, & Guthrie, 1990).

Assessment related issues

Three of the studies presented contain psychometric evaluations of the Defense Style Questionnaire – 48 (DSQ-48), the BPD Checklist and the Borderline Personality Disorder Severity Index-IV (BPDSI-IV). As already pointed out in the introductory chapter, there is an interface between assessment and conceptualization. The relations between these two facets can take two directions: (1) assessment leading to support or rejection of (underlying) conceptualizations and (2) conceptualizations leading to development or use of tailor-made assessment instruments.

The DSQ-48 study pre-eminently emphasizes the importance and necessity of continuous empirical evaluation in that it is possible that relations between assessment and concepts can change, or as in this case, were adjusted. In the

present study on defense style, it was decided that the general conceptual meaning was supported, as BPD-patients could be well described within the framework, but adjustments in the classification of defense styles were suggested. Difficulties and differences in ordering defense mechanisms have been likewise encountered and reported by others, and often relate to differences in assessment methods, such as self-report, Q-sort and observer-rated instruments (Bond, Gardner*, et al.*, 1983; Perry & Cooper, 1989; Vaillant, 1976). Even though it is one of the few aspects within the psychoanalytical tradition that is scientifically investigated for decades, one can wonder whether the self-report DSQ-48 is the best suitable option for testing theoretical defense issues. The self-report format probably limits assessment of defense mechanisms to a more strategic type, excluding types that are context-dependent. The clinical utility of defense mechanisms is quite clear, as these are solidly incorporated in psychodynamic oriented (manual-based) treatments like Transference Focused Psychotherapy. Still, after reviewing the literature on defense mechanisms over the last decades, it appears especially difficult to pinpoint, assess and consistently describe mature defense mechanisms in an overall theoretical and clinical concept. In that respect, immature and neurotic defense mechanisms seem more unequivocal. This impression is further supported by the results of the treatment study, in which the DSQ-48 was included as a secondary outcome measure of TFP-based personality change. The principal component analyses of all secondary measures revealed that the mature defense mechanisms scale was the only scale, of 14 scales, to behave differently (and was therefore excluded from subsequent analyses). In contrast, DSQ-immature and neurotic defense mechanisms and IPO-lower level defenses (similar to immature defense mechanisms) confirmed the hypotheses as patients' improvement and healthier daily functioning also became visible in reduced use of immature and neurotic defenses. These findings contribute to the conceptual validity of immature and neurotic defense categories in themselves. On the other hand, toning down the conceptual stability, the newly proposed factor labels (distrust, self-protection, self-sacrifice, avoidance and control) and the factors' order from most pathological to healthy, make the questionnaire appear less specific for psychoanalytical theory. The information obtained from a DSQ-43 could probably also be framed within cognitive behavioral theory, where it would refer to the use of coping strategies.

The Young Schema Questionnaire and the Personality Disorder Belief Questionnaire – BPD section were (self-report) cognitive theoretical measures of personality change in the borderline treatment study. Like the immature and neurotic defense scales, these measures confirmed the hypotheses (improvement led to reduced presence of pathogenic schemas and beliefs) and showed their conceptual validity in the cognitive framework of BPD.

The assessment - conceptual relations of both the BPDSI-IV and the BPD Checklist with the DSM-IV BPD diagnosis presently have an excellent fit. The concurrence in BPDSI-IV and BPD Checklist score patterns for different (non-) patient groups, despite the different formats, can be viewed as further support that the current BPD-concept is well reproduced. The internal structure of the 'unstable relationships' criterion of the BPD Checklist differed somewhat from the BPDSI-IV division of this criterion in 'partner relations' and 'relations with other people', but this difference seems to play a relative minor role as both instruments yield such similar results. It will depend on the purpose and setting, in addition to other practical arguments, which instrument will be used. The applicability of these instruments is, in essence, identical. The correspondence between the BPDSI-IV and BPD-Checklist with regard to conceptualization and application purposes, and most importantly for displayed 'behavior' in different populations, opens up new possibilities. One prominent example concerns the exploration of perceptional differences of actual symptomatic change between a therapist, the patient, and an independent rater (the last one only for the BPDSI-IV). This will increase empirical understanding of BPD-specific change mechanisms due to treatment, but also enables therapists to objectify his/her perceptions and hypotheses of patients' behavior. The application of assessment instruments in treatment (as 'independent' tool) can also serve as an external pathway to introduce relevant topics in the treatment process.

Clinical cutoff scores, as well as norms with accompanying specificity and sensitivity, were calculated for both total scores of the BPDSI-IV and the BPD-Checklist. The severity index is of primary interest but cutoff scores on the separate criterion measures could be of additional value to further document patients change patterns during treatment. Different scenarios relate to this issue. Criterion cutoff scores can possibly test the (manual-based) treatment assertion that specific BPD-problem areas must be addressed in a certain order or specific treatment phase. For example, if acting out in BPD is indeed addressed at start of a treatment, criterion 4 (self-destructive impulsivity) and 5 (parasuicidality) should show reductions in the first time frame. Scores for identity disturbance seen as a more fundamental feature of BPD are expected to diminish at much later times. For treatments aiming at specific symptomatic improvement instead of personality change, the application of one or some BPDSI-IV criteria could be sufficient and also more appropriate (e.g. Verheul, van den Bosch*, et al.*, 2003). In this line, BPDSI-IV criterion cutoff scores were determined based on the BPDSI-IV study population, which can be found in Appendix II.

Clinical implications and future research

The studies presented in this thesis demonstrate that BPD can be well and justifiably explained in a cognitive or a psychoanalytical theoretical framework and these frameworks can be fruitfully applied through SFT and TFP in the treatment of borderline patients.

The DSQ-48's validity and use in clinical practice are satisfactory to describe BPD-patients, as they are mostly characterized by an immature/primitive defensive style. When the overall structure of mature, neurotic and immature defensive styles is pursued for less defined patient groups, one should consider the possible limitations (*chapter 3* and previous paragraph). The proposed 5-factor model (distrust, self-protection, self-sacrifice, avoidance and control) over 43 items may then be a better statistically coherent framework to describe patients' defense or coping style. The promising results on the BPDSI-IV and the BPD-Checklist, support the use of these instruments in different mental health care settings and for different purposes as screening instrument, treatment outcome measure or for therapists' individual use.

In spite of all the positive findings and implications with respect to assessment instruments, one can also conclude that caution should be maintained since replication studies are needed, which is always the case with relatively new assessment instruments. In addition, further refinement and extension to other clinical control groups (especially Cluster B personality disorders, but also schizophrenics) is indicated. A limitation to all proposed cutoff scores and norms is that only one sample was used in calculating these scores. So, cutoff scores (including specificity and sensitivity) should also be re-examined in future research. Furthermore, future developments within the DSM borderline classification system will probably be adapted into new versions of the BPDSI and BPD-Checklist. A different noteworthy remark involves the many promising responses on the initial report on the previous version of the BPDSI-IV (Arntz, van den Hoorn*, et al.*, 2003). This not only exemplifies the need there is for BPD-specific assessment instruments, but also led to translations of the BPDSI-IV in Chinese, English, German, Hebrew, Italian, Korean and Norwegian. Consequently, new psychometric evaluations of the BPDSI-IV are currently in progress, with the valuable supplement that cross-cultural differences are simultaneously studied. The German and Italian BPDSI-IV already demonstrated excellent reliability and validity (personal communication). The BPDSI-IV is currently being used for research purposes in Australia, China, Germany, Israël, Italy, Norway, United Kingdom and the United States of America (personal communication).

Some cautionary notes should be made with respect to possible clinical implications after this borderline treatment study. The hiatus in available treatments for BPD-patients existed for a long time, but is now slowly being filled during the

last decade with treatments for severely impaired BPD-patients as Dialectical Behavioral Therapy (Linehan, Armstrong*, et al.*, 1991; Linehan, Heard*, et al.*, 1993; Linehan, Schmidt*, et al.*, 1999; Linehan, Tutek, Heard*, et al.*, 1994) and Mentalization Based Treatment (Bateman & Fonagy, 1999; 2001). As our study progressed, an increased eagerness and tendency to get ahead of the actual results was observed in the clinical field. Although the present study has positive results, and proved SFT to be more effective in treating BPD-patients than TFP, one cannot conclude that SFT is automatically the best evidence-based outpatient BPD-treatment and that TFP is only second choice. It must be emphasized that one RT never is a sufficient basis for guidelines. Replications of the present results are needed, as are (historical) comparisons of SFT and TFP to other manual-based treatments and so-called natural course/treatment-as-usual. Considering the Dutch situation in which the only psychotherapeutic treatments that the ministry of health, welfare and sport allows to be paid for by the generated health care funds are traditional psychodynamic treatments, it appears that comparing SFT to these traditional psychodynamic treatments is highly necessary. Furthermore, a historical comparison of the first year of SFT and TFP with a Dutch 1-year DBT efficacy study (Verheul, van den Bosch*, et al.*, 2003) may be an interesting and realistic possibility as the initial plans for the grant application which funded the present RT, included a collaboration with the Dutch DBT study group. Methodological and practical problems eventually led to two separate studies but the main outcome measure (BPDSI-IV) remained the same.

The circumstances under which the present treatments were administered were, despite some methodological limitations, quite ideal. However, as already became clear, governmental and health care insurer's policies have changed during the study period, as a result of which the investigated SFT-treatment frequency and duration, is not realistic anymore for BPD-patients in current clinical practice. On the other hand, recent developments concerning the implementation of diagnostic-treatment-combinations (DBC's) throughout the Dutch health care system opens up new perspectives, as health insurers will have to negotiate with mental health care facilities. So, the generalizability of the results to the present mental health care situation and to other health care settings also has to be demonstrated in implementation studies. Another argument in this respect is that BPD-patients in outpatient settings are mostly female, like our study group, but that BPD-patients in other settings (e.g. forensic and addiction) are predominantly male. The number of male BPD-patients in the present study sample was too small to make any specific statements on differences in treatment results between men and women. A first development to investigate the generalizability of SFT with an implementation study of outpatient SFT for BPD in general psychiatry has recently started (Nadort, van Dyck, Spinhoven*, et al.*, 2005). In the implementation study, SFT will consist of 50 sessions (within the present regula-

tions) over 1.5 year. On another level, generalizability of SFT to other personality disorders than BPD will also be investigated in 2006 (Arntz, Severens, Evers*, et al.*, 2005; Bernstein, 2006).

This SFT session-reduction introduces another issue; effectiveness of SFT and TFP is demonstrated for the manuals as applied in the treatment study but not for any other SFT/TFP-based treatments. When adjustments are made to the SFT or TFP manuals, for any reason, one should realize that the empirical support of adjusted SFT/TFP manuals cannot be fully based on the present SFT/TFP effectiveness study. Future research should determine how and which elements make SFT and TFP effective treatments.

Another point of attention for therapists who consider to additionally train in SFT or TFP, is that working with SFT or TFP adequately, requires much more training (and ongoing peer supervision and supervision) than many other manual-based treatments for Axis-I disorders. Apart from post-doctoral cognitive-behavioral or psychodynamical training, the reading of the manuals referred to will not automatically make a therapist a SFT- or TFP-therapist (Clarkin, Yeomans*, et al.*, 1999; Young, Klosko*, et al.*, 2003). A Dutch SFT-training has been developed, piloted and tested (Nadort, van Dyck*, et al.*, 2005), and it could be concluded that a 50-hour training program, in combination with peer supervision and supervision, is a sufficient basis for training therapists in SFT. Furthermore, several Dutch regional post-doctoral training institutes (RINO's) started courses in which study therapists teach SFT and TFP.