Borderline personality disorder, substance abuse, and dialectical behavior therapy
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CHAPTER I

General Introduction

1.1 Background

Borderline personality disorder (BPD) is probably one of the most stigmatizing mental disorders. It is often undiagnosed, misdiagnosed, or treated inappropriately. Clinicians may limit the number of BPD patients in their practice or drop them as 'treatment resistant'. Because of its classification as an Axis-II disorder, BPD is excluded from many managed care and healthcare plans. People with BPD often adopt maladaptive or impulsive behaviours to cope with their pain. These behaviours account for some of the nation’s major public health problems. BPD has been found to be comorbid with many other conditions, such as substance abuse (Grilo et al., 1997; Crib et al., 1999), domestic violence (Dutton et al., 1993; Dutton, 1995), eating disorders (Dennis, 1998), unprotected sex and increased risk for AIDS (Hull et al., 1993), stalking (Lewis et al., 2001), and impulsive aggression (Goodman & New, 2000). BPD has an estimated suicide rate of 10%. It is frequently masked by commonly known comorbid conditions that are easier to identify. Whatever symptom is identified first usually determines the door the person opens into the health-care system. What is treated may be a maladaptive coping mechanism rather than the underlying syndrome. It is often the place of entry that defines the primary diagnostic label (Coccaro & Kavoussi, 1997).

The frequent misdiagnosis of BPD and omission from studies may, next to the reasons connected with the negative connotation that goes with the disorder, be attributable to the lack of an easily administered structured diagnostic interview capable of generating
reliable psychiatric diagnoses in community and public health settings. Placement on Axis-II in the DSM-IV, the confusing name of the disorder and its comorbidity with other illnesses such as substance abuse or PTSD appear to be contributing factors in the under service and under recognition of BPD as a severe and disabling disorder. Because of its overlap with other disorders, evaluation of BPD research is difficult.

There is an alarming shortage of trained therapists for these patients. In the United States, the International Society for the Study of Personality Disorders lists its members by nationality. Some nations/countries list only one BPD researcher or clinician, others just 2 to 5. Considering that the estimated BPD prevalence is 2% to 3% of the general population, this number of treatment professionals is much too low (Kessler, 1994).

Why is BPD the recipient of such professional disregard, and especially the BPD patient with comorbid substance using problems? And, maybe even more important, can this be changed? Because of the multi-problem character of BPD, it can be expected that symptom-specific programs will be developed instead of integrated ones. This however would introduce an undesirably high degree of differentiation that poses an enormous organizational challenge for the mental health field. And, it would stress the lack of trained therapists even more. Is it possible to give effective treatment to patients with impulse control disorders who tend to have multiple problems simultaneously or, alternatively, tend to shift from one to another type of problem behaviour? And, is it possible to recruit therapists who want to treat BPD patients in an, evidence-based, effective way?

These questions were the main reasons that have led to the decision to study DBT in the Netherlands. A research program was added because we wanted to replicate and extent Linehan's original study with this group of patients. There are no other studies that have included borderline patients with and without substance abuse problems, recruited from addiction treatment services and from general psychiatric services. Maybe our results will show the feasibility of DBT for multi-problem BPD patients and underscore the need of more integrated DBT programs and DBT trained therapists.

The primary aim of this chapter is to provide insight in the Borderline Personality Disorder and its severe symptomatology, and to give an overview of Dialectical Behavior Therapy in order to make understandable why a Randomised Controlled Trial was carried out in a group of Dutch female borderline patients, with and without substance abuse problems. The chapter ends with a description of the structure of the thesis.
Borderline Personality Disorder

Already in the 19th century, patients who could not be designated to ‘neurotic’ or ‘psychotic’ categories were placed in the ‘borderland’. A hundred years later, in the beginning of the 20th century, psychoanalysis reinstated the use of a special name for a group of patients that seemed not to be treatable and showed increasing therapy interfering behaviour during sessions. The term ‘borderline’ originates thus from the concept that a psychopathological domain exists between neurosis and psychosis (Stern, 1938). The psychopathology as described by Stern, was not only called ‘borderline’, but also other diagnostic labels were used (e.g. ‘bad hysteria’, ‘pseudo-neurotic schizophrenia’). Most analysts placed their borderline patients near the psychotic end of the spectrum, at the border of schizophrenia. Knight (1953) was the one to question this relationship with psychosis, because of the intact capacity for reality testing. The concept was given clearer definitional boundaries by Kernberg (1967), who developed the concept of the ‘borderline personality organization’, as a structural diagnosis. For 35 years the concept of the ‘borderline patient’ exclusively belonged to the analytic literature, borderline being a specific early-childhood developmental disorder. The first version of the DSM system did not mention the borderline personality disorder as a diagnosis (APA, 1952), nor did the DSM-II (APA, 1968). Gunderson (1975) started the empirical research of BPD by describing the operationalized criteria for borderline patients. Since 1980 three main, not fully overlapping borderline concepts are used: the structural concept of Kernberg (1967), the descriptive criteria of Gunderson (1975) and the criteria for the borderline personality disorder by Spitzer (1979). Since the DSM-III (APA, 1980), the pathology (suicidality, impulsivity, affect instability and unstable relations) is recognizable as a distinct clinical syndrome, the Borderline Personality Disorder (BPD). The DSM-IV (APA 1994) describes BPD as: ‘A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five or more of the nine described criteria’. It need to be mentioned that categorical descriptions of BPD like the DSM, create diagnostic problems because of the overlap with other personality disorders (Verheul et al., 1995), the heterogeneity within the category and the conceptual fuzziness of the difference between Axis-I and Axis-II (APA, 1995). The BPD diagnosis, however, has proven to be one of the most reliable diagnostic categories, although the necessity of a careful diagnostic process is stressed by many authors (e.g. Sanislow et al., 2002; Hudziak et al., 1996).

There have been many hypotheses about the aetiology of the disorder, ranging from a firm relationship with the schizophrenic spectrum to borderline as a disorder belonging to the affective or impulse control spectrum (Inghenhozen, 1990; Siever
As a consequence, different medications were tested, including antidepressants, neuroleptics and mood stabilizers. At the same time, different psychotherapeutic approaches were developed and tested, ranging from 'no treatment as the treatment of choice' (Frances, 1986), through short-term outpatients treatments, to long-term outpatient cognitive behavioural treatments (e.g. Beck & Freeman, 1990; Linehan, 1991) and partial hospitalisation and psychodynamic psychotherapy (e.g. Bateman & Fonagy). With the appearance of DSM-III, the diagnosis 'borderline' expanded into all domains of psychiatry. Patients coming from all social levels were being diagnosed as 'BPD' and psychoanalytically oriented psychotherapy could no longer rationally be regarded as the treatment of choice for all those who now entered under this diagnostic label. Despite these developments, borderline patients are still seen as 'therapeutically challenging'. According to Stone (1993), we usually come to recognize who our borderline patients are because they refuse to leave the session when the time is up, or they come in with a wrist bandaged up from a self-damaging gesture, or they call us at two in the morning in some quite preventable crisis. In short, these patients are still misdiagnosed and subsequently do not receive adequate treatment. This is (partial) the result of the fact that the incidence of this severe disorder is still underestimated, because it frequently stays hidden behind more striking Axis-I pathology (parasuicidality, depression, substance abuse, PTSD etcetera), while of course the lack of effective treatments for BPD contributes to the fact that patients prefer not to be diagnosed as BPD. It is remarkable then that research of epidemiological aspects was developed no more then twenty years ago.

1.1.2 Epidemiology of BPD

BPD is a persistent and severe mental disorder. The prevalence is estimated to be about 2% of the general population, about 10% among individuals seen in outpatient mental health and addiction clinics, and about 20% among psychiatric and substance abuse inpatients (APA 1994, Verheul et al 1995). Borderline personality disorder is characterized by intense negative emotions including depression, anger, self-hatred, and hopelessness. In coping with these emotions, BPD individuals often engage in impulsive maladaptive behaviours, including suicidal behaviours and substance abuse.

The majority of patients with BPD engage in suicide attempts and/or self-mutilation, and 7-10% of them eventually die because of suicide (Perry 1993; Frances, et al., 1986). BPD is the only DSM-IV diagnosis for which parasuicide is a criterion and parasuicide is

Parasuicide (Linehan, 1993a; Kreitman, 1977) is a label for (1) nonfatal, intentional self-injurious behaviour resulting in actual tissue damage, illness, or risk of death; or (2) any ingestion of drugs or other substances not prescribed or in excess of prescription with clear intent to cause bodily harm or death. It includes both actual suicide attempts and self-injuries with little or no intent to cause death. Parasuicide includes behaviours commonly labeled 'suicide gestures' and
thus considered a ‘hallmark’ of BPD. Rates of parasuicide among patients diagnosed with BPD range from 69 to 80% (Clarkin et al., 1983; Cowdry, et al., 1985; Gunderson, 1984). Rates of suicide among all individuals meeting criteria for BPD, without parasuicidal behaviour, are high and are doubled when those with a history of parasuicide are included (Stone, et al., 1987).

Research over the past two decades indicates that among those served by community mental health agencies, a sub-population utilizes a disproportionate amount of inpatient psychiatric services: between 6 to 18% of all persons admitted to inpatient psychiatric treatment account for 20 to 42% of admissions (Carpenter et al., 1985; Geller, 1986; Green, 1988; Hadley et al., 1990; Surber et al., 1987; Woogh, 1986). People with BPD are frequently among the high utilizers of inpatient psychiatric services. It is estimated that between 10 - 40% of high utilizers have been diagnosed with BPD (Geller, 1986; Surber, et al., 1987; Widiger & Weissman, 1991; Woogh, 1986).

It can be concluded that BPD has a high incidence, goes with serious physical and mental consequences and entails great, not well-grounded expenses on the community mental health system.

1.1.3 BPD and Comorbidity

BPD is the most commonly diagnosed personality disorder in both inpatient and outpatient settings (Widiger & Trull, 1993) and it rarely occurs in isolation. BPD has been connected, etiological and symptomatological, to several other mental disorders, with high comorbidity percentages with other Axis-I and Axis-II diagnoses, and with substance abuse, trauma and dissociation being prominent among them (Zanarini et al., 1998, 1990, 1989; Gunderson et al., 1985).

Many studies have shown significant comorbidity between BPD and substance use disorders (SUD) or substance abuse (Trull et al., 2000; Links et al., 1995; Oldham et al., 1995; Dullit et al., 1990; Zanarini et al, 1989; Zimmerman & Coryell, 1989; Akiskal et al. 1985; Loranger & Tulis, 1985). The reported prevalence rates of SUD among patients with BPD are so high, (39% - 84% median 67%: Dullit et al., 1990; Links et al., 1995; Zanarini et al, 1989, 1990, 1998), that some authors have suggested that SUD and BPD must be causally linked in some way (Verheul et al., 1997).

Also, a high incidence is reported of childhood physical and sexual abuse among female patients with BPD: 55% - 80% (Herman et al., 1989; Ogata et al., 1990; Paris et al., 1994; Salzman et al., 1993; Westen et al., 1990; Roth et al., 1997). The same is 'manipulative suicide attempts'. It is distinguished from suicide, where intentional, self-inflicted death occurs: suicide threats, where the individual says she is going to kill or harm herself but has yet to act on the statement; almost suicidal behaviours, where the individual puts herself at risk but does not complete the act (e.g. dangling from a bridge or putting pills in her mouth but not swallowing them); and suicide ideation.
true for PTSD in female borderline patients: 33% - 56% (Swartz et al., 1990; Zanarini et al., 1998).

Childhood trauma has been associated with both adult SUD (Langeland et al., 2002; Langeland & Hartgers, 1998; Brown et al., 1991) and BPD (Sabo, 1997). It, therefore, comes as no surprise that high levels of dissociation among BPD patients are reported (Carlson & Putnam, 1993). The relationship between childhood trauma and adult dissociation seems to be somewhat more complicated in patients with SUD, where dissociation in traumatized patients is often remarkably low. Until now, nothing is known about the levels of dissociation in traumatized BPD patients with a comorbid SUD.

In conclusion: all research of efficacy of treatment of BPD needs to pay attention to comorbid disorders.

1.1.4 BPD and treatment

Parasuicidality and self-injurious behaviour are seen as the most characteristic features of BPD. Many researchers and clinicians regard parasuicidality as a manifestation of dissociation, associated with early-childhood traumatisation: a primary coping style to block out intolerable cognition and emotions, in order to master childhood physical and sexual abuse (Langeland et al., 2002; Brunner et al., 2000; Ross-Gower et al., 1998; Zlotnick et al., 1996; Barstow, 1995; Brodsky et al., 1995). Self-injurious BPD patients even display more dissociative symptoms than patients who do not engage in self-injury (Shearer, 1994). Finally, substance abuse may diminish an already vulnerable BPD patient's capacity for self-protective behaviour and further disinhibit control (Zanarini, 2000). Using drugs becomes a viable although destructive coping mechanism. Some authors have even proposed that alcohol and drug use might be some sort of chemical dissociation (e.g. Langeland et al., 2002).

Because of the high incidence and the important consequences, dissociation and self-mutilation are usually considered a necessary focus of treatment in BPD programs. Borderline patients with SUD, however, tend to be treated differently from those without SUD. The differential treatment occurs in clinical practice, but also in scientific studies. It has often been observed and reported that borderline patients with SUD experience great difficulties when applying for treatment. This can be caused by the negative connotation of the diagnosis 'BPD' (van den Bosch, 1996). Especially the BPD + SUD patient seems to be stereotyped as difficult to treat, unsympathetic, unwilling, unreliable, and with a poor prognosis. BPD patients belonging to this group usually are refused admission to the mental health service system until they stop using substances and cannot enter substance abuse treatment system until suicidal and other self-destructive behaviours are under control (e.g., Verheul, 1997). Although substance
abuse is generally considered a typical borderline manifestation rather than an independent comorbid condition, there are no integrated treatment programs for BPD patients using substances. It therefore comes as no surprise that the prognosis is generally regarded to be poor. In the daily practice of mental health and substance abuse services, clinicians seem to be prevented from undertaking integrated and collaborative treatments for dual diagnosis patients, and the mental health field shows a tendency toward differentiation between symptom- and disorder-specific modules. Only two types of psychosocial treatments of BPD have shown promising, although not well-established (cf. Crits-Christoph et al. 1995), empirical evidence for their efficacy, i.e. psychoanalytically oriented partial hospitalisation (Bateman & Fonagy, 1999, 2001) and outpatient Dialectical Behavior Therapy (e.g. Linehan, 1991, 1993, 1999). No efficacy studies compared BPD patients with SUD with BPD patients without SUD. Usually, BPD patient’s comorbid with SUD are excluded from participation. When in 1995 the decision was made to start this study, Dialectical Behavior Therapy (DBT) was the only BPD treatment with some empirical support. Therefore it was decided to study the possibility of the implementation of DBT in the Netherlands and to examine the long-term results of DBT in a population of female borderline patients with and without substance abuse problems.

It can be concluded that till now there are no treatments, neither pharmacological nor psychosocial, for BPD with well-established efficacy (APA Practice Guideline, 2001). Dissociative phenomena and coping strategies play an important role in BPD. Therefore, it can be expected that the combination BPD-SUD creates special problems in the examination of efficacy of psychotherapeutic treatments, and thus should be given specific attention.

1.2 Dialectical Behavior Therapy

DBT is a comprehensive psychosocial treatment developed specifically for severely dysfunctional and chronically suicidal individuals with borderline personality disorder. The philosophy, biosocial theory, treatment targets, structure, strategies, and protocols of standard DBT are described in two treatment manuals (Linehan, 1993a, 1993b), which are also available in Dutch translation (Linehan, 1996, 2002).

DBT assumes that individuals with BPD lack important interpersonal, self-regulation (including emotional and behavioural regulation) and distress tolerance skills. Also, personal and environmental factors frequently block and/or inhibit the use of behavioural skills that individuals do possess; these same factors often inadvertently
reinforce dysfunctional behaviours. Furthermore, DBT assumes that people with BPD are not at fault for having these motivational and skills deficits; these individuals are trying their best to cope with life. In spite of these assumptions, DBT also assumes that people with BPD must nonetheless work harder to learn and apply the necessary skills needed to improve the quality of their life and must fundamentally give up and replace dysfunctional coping behaviours (e.g., cutting, suicide attempts, abusing drugs, etc.) by functional behaviours. It logically follows that individuals with BPD need help in order to enhance their motivation and skills to develop a life worth living.

Many of the BPD clients enter treatment with severely disordered and dysfunctional behaviour. The goals of treatment for this first stage of DBT treatment are behavioural control, stability, and connection with treatment and care provider. Consistent with other behavioural treatments, Linehan (1993a) has specified a pragmatic set of hierarchically-arranged behavioural targets for this stage: decrease suicidal and other life-threatening behaviours, decrease therapy-interfering behaviours (e.g., not attending or coming late to therapy sessions, falling asleep during sessions, not completing therapy homework assignments), decreasing quality-of-life interfering behaviours (e.g., substance abuse, homelessness, unemployment, etc), and increasing behavioural skills. Comprehensive DBT treatment for individuals in stage one includes five important functions necessary to decrease dysfunctional behaviours, to increase functionality, and to enhance quality of life. These functions include: 1. enhancing behavioural capabilities; 2. improving motivation to change; 3. assuring new capabilities generalize to the natural environment; 4. structuring the environment in the ways essential to support client and therapist capabilities; and 5. enhancing therapist capabilities and motivation to treat patients effectively.

These five functions are addressed within four different standard treatment modes, including weekly individual psychotherapy (50 - 60 minutes weekly), group skills training (150 minutes weekly), a consultation team meeting for providers of treatment to BPD clients receiving DBT (60 minutes weekly), and as-needed telephone consultation (for in vivo skills coaching to avert crises, facilitate skills generalization, and to repair between-session conflicts or misunderstandings between therapist and client).

The individual advances to the second stage of treatment once behavioural control is achieved (e.g., when faced with situations that would historically trigger dysfunctional behaviour, the individual is successful in applying skilful behaviour to solve or withstand the problem rather instead of dysfunctional behaviour). The focus during this second stage is emotional experience and processing of trauma from the past. The third stage emphasizes resolving ordinary problems in living (e.g., ordinary happiness and unhappiness). And then there is a fourth stage (transcendence) for those who
Desire a more spiritual or meaningful existence. The focus of the DBT research has mainly been on the first stage: achieving behavioural control.

DBT is based on behaviour theory. Behavioural principles and learning theory are among the theories that form the backbone of DBT. Consistent with other behavioural approaches, DBT assumes that all behaviour, including dysfunctional behaviour, occurs as a result of prior learning or biology. People with BPD learned to react in certain maladaptive ways to stimuli.

In order to be able to change maladaptive behaviours, it is necessary to know which factors are controlling the behaviour by means of a thorough behavioural assessment of the problem behaviour. Early on in treatment, the patient is taught that behavioural analysis forms the backbone of each session and the way to fill in the diary cards is explained and agreed upon. This is done to be able from the first moment on to reveal by analysis the problematic behaviour the patient mentions (monitoring) and to make it ready for change.

It is important to mention here that the application of behavioural analysis, and the start of behavioural change can only begin after commitment of the patient is obtained according to the therapy and after therapist and patient have reached agreement about goals and targets of change (Linehan, 1993a.).

DBT uses a number of core methods that are also used in behaviour therapy. Next to the already mentioned behavioural analysis we find solution analysis and solution strategies, the skills training (acquisition and strengthening of new skills), insight strategies, contingency management, exposure, cognitive modification, didactical interventions, orienting strategies ('what is the goal of our cooperation'), and the acquisition and strengthening of commitment.

One other important behavioural principle that is applied in DBT is that besides the acquisition and strengthening of new behaviour, generalization of that same behaviour must take place in every relevant context (Linehan, 1993a). Because it is important that patients show effective behaviour outside the therapy, generalization of new, adaptive behaviours needs to occur. Generalization is aimed at during role-play in the group session, in homework assignments of the skills training and through the phone consultation.

DBT differs from behaviour therapy pur sang in the fact that DBT integrates acceptance-based approaches with cognitive-behavioural change-based procedures. Validation, mindfulness practices, reciprocity, and a focus on the patient-therapist relationship are integrated with basic behavioural procedures of skills training, exposure-based procedures, cognitive modification, contingency management; and problem-solving The concept of dialectics, with its emphasis on synthesis of
these polar opposite positions, provides a fresh lens in which to envision treatment possibilities. DBT can be differentiated from other therapies by the systematic use of therapist-patient telephone consultation, and, the emphasis in DBT given to the consultation team, where therapists' capabilities and motivation to treat patients effectively are focus. In summary, DBT is a multi-model and rather complex and comprehensive treatment strategy that is highly structured and fully manualized.

A critical overview of the empirical basis of DBT (Scheel, 2000) concludes that the findings to date are encouraging and that careful considerations of multiple factors are needed to reach the conclusion that DBT is effective treatment of BPD symptomatology. Our results strongly enhance the empirical status of DBT (Verheul et al., 2003; van den Bosch et al., 2002).

1.3 Aims of the study and structure of the thesis

It has been described that both mental health treatment centres and research programs examining efficacy of treatments of BPD exclude substance abusing BPD patients from their treatment programs as well as from their research programs. Comorbidity percentages of BPD and substance abuse are high, resulting in poor referral conditions for many patients. In the Jellinek Center for substance abuse treatment in Amsterdam, the treatment of substance abusing, suicidal BPD patients also proved to be ineffective. Only one study (Linehan, 1991, 1993) has shown that standard DBT compared to treatment-as-usual (TAU) is a treatment program that seems to be effective in reducing severe borderline symptomatology in borderline patients without substance abuse. However, the meaning of the results is weakened by the fact that samples are small, and the developer conducted all the published studies. The results, however, show that DBT seems to enhance treatment retention, that DBT seems to reduce severe dysfunctional behaviours, and that DBT seems to reduce the number of hospitalisation days.

In 1995 the Jellinek Center and the Amsterdam Institute for Addiction Research (AIAR) decided to replicate Linehan’s original study in a randomised controlled trial of DBT in a mixed population of borderline patients with and without comorbid substance abuse. Several research goals were formulated. The main goal was to examine the feasibility of DBT in the Netherlands and to test the efficacy of DBT by non-developers (i.e. Marsha Linehan) in a mixed population of borderline patients with and without substance abuse problems, in a larger sample and with more rigorous
methodology. Severity of (para) suicidal behaviour, treatment retention and severity of substance abuse problems were defined as outcome parameters of the study. Logically, the development of an integrated, standard outpatient DBT program in Amsterdam was a prerequisite.

This thesis includes four parts. Part I consists of the introduction. Part II deals with the role of SUD comorbidity in female borderline patients (Chapter 2 and 3). Part III focuses on the efficacy of DBT (Chapter 4, 5 and 6). Part IV describes the implementation of DBT, and the clinical implications and conclusions of the study (Chapter 7 and 8).

1.3.1 Part II. Characteristics of the research population: the influence of comorbidity
In Chapter 2 the central question is whether the study results could be influenced by etiological and symptomatological differences between the substance abusing and non-substance abusing BPD patients. There is hardly any research on the treatment of BPD in which substance abuse is not an exclusion criterion. To our knowledge this is the first study to include a mixed sample of borderline patients with and without substance abuse. It is at least remarkable that this issue has been rarely focused on empirically. As a first step, the differences and similarities in clinical characteristics and etiological factors between female borderline patients with \(n=33\) and without SUD \(n=31\) are investigated. Clinical characteristics include borderline symptom severity, Axis-I comorbidity, and treatment history. Etiological variables include family history of SUD, and history of childhood trauma and adult victimization.

In Chapter 3, as a second step, the question is answered whether the study results could be influenced by differences in coping mechanisms used by the female substance abusing BPD patients \(n=33\) and the non-substance abusing female BPD patients \(n=31\). Substance abusers might have learned to cope with childhood sexual abuse (CSA) and childhood physical abuse (CPA) through a mechanism of ‘chemical dissociation’ which is developed instead of psychological dissociation or which may have replaced original coping mechanisms of psychological dissociation (Langeland et al., 2002). The association of CSA/CPA and dissociative symptoms and PTSD among BPD patients without SUD is consistent. It is hypothesized then, that in case of ‘chemical dissociation’ differences will be found in the associations CSA/CPA and dissociative symptoms and PTSD between the BPD patients without SUD, and those with comorbid SUD.

1.3.2 Part III. Efficacy
The female borderline patients of our study sample meet criteria for DSM-IV borderline personality disorder according to both the Personality Diagnostic Questionnaire

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and the Structural Clinical Interview for DSM-IV Axis-II Personality Disorders (SCID-II). Most of them engage in self-damaging and (para) suicidal behaviours.

Prevention of parasuicidal acts is of extreme importance in the treatment of borderline patients. As a consequence, predictive validity of intermediate variables is of great importance. In Linehan’s study (1991, 1993) the Reasons For Living Inventory (RFL; Linehan et al., 1983) was used as an instrument with predictive validity for self-damaging and suicidal behaviour. Linehan et al. (1993), furthermore, hypothesized that the effect of cognitive behaviour therapies, in particular Dialectical Behavior Therapy, is partly mediated by an increase of reasons for living. We, however, based on cognitive behavioural therapeutic explanations of parasuicidal behaviour as coping behaviour, wondered whether the RFL could be seen as an intermediate variable or just as a coping scale. Although the possible character of the RFL as intermediate variable in the efficacy study was not part of our research questions, we wanted to examine the associations of subscales of the Reasons for Living Inventory with coping strategies. In Chapter 4 the predictive validity of Survival and Coping Beliefs (SCB), one of the subscales of the RFL, is examined.

The replication of Linehan’s original study, i.e. efficacy of DBT compared to TAU in the treatment of female BPD patients, is investigated in Chapter 5. In a randomised controlled trial, the efficacy of DBT in a group of 58 female BPD patients on the primary target behaviours of DBT (suicidal, self-mutilating, and self-damaging impulsive behaviours; treatment retention) is examined. In this chapter we also investigated whether DBT is equally efficacious among the female BPD patients with high and low levels of risk behaviours.

In chapter 6 the question whether the results found at 12 months hold at follow-up, after a six-months period, is answered. It is examined whether the difference between TAU and DBT holds for BPD symptomatology. It is also investigated whether TAU and DBT differ at 18 months follow-up, compared to the 12 months results, with regard to level of substance abuse.

1.3.3 Part IV. Clinical Implications, Implementation, Conclusion
Chapter 7 examines whether standard DBT is applicable in the Netherlands and effective in the treatment of BPD symptomatology and substance abuse problems. The question what specific problems were encountered and what solutions were found for these problems during the implementation of DBT in Amsterdam, are answered. It is examined whether standard DBT is equally efficacious in reducing borderline symptomatology among those with (n=31) and those without comorbid substance abuse (n=27), whether standard DBT is efficacious in terms of reducing the severity of the substance use, and what the long-term effects of the treatment are.
Also, implications for the training of mental health professionals are discussed. Chapter 8 gives an overview of the study results, discusses the limitations of this research, recommends implications for future studies, and finally comes to conclusions.
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