Borderline personality disorder, substance abuse, and dialectical behavior therapy
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Introduction

The first aim of this chapter is to summarise and discuss the results and conclusions that can be drawn from this study. In order to do so, our results are compared to findings from other studies, and limitations of the study are highlighted.

A second aim is to give more insight in the process of implementation and research. There are many obstacles that need to be cleared if a treatment program is implemented and a research program is started, especially for an RCT with parasuicidal BPD patients. We will discuss the problems we encountered and will describe the solutions we found.

Finally, during and after the study period an overwhelming outburst of actions in connection to DBT took place in the Netherlands and in some of the surrounding European countries (e.g., development of programs, publications, training etceteras). A brief overview of these developments is given.
8.1 Summary of the study results

The central themes of this thesis were: (i) to study the feasibility of BPD in The Netherlands in a mixed population of BPD patients with and without substance abuse problems, and (2) to study the efficacy of DBT in this population. In order to study the feasibility, borderline patients with and without substance abuse problems were compared with regard to symptomatology, etiological factors and the relationship between childhood traumatisation and dissociation. Efficacy of DBT was tested in a randomised controlled trial using response after 12 months treatment and sustained response after 6 months follow-up without DBT as the primary outcome parameters.

It should be noted that the first stage of standard DBT, and focus of our research program, has two priorities: to keep the patient alive and to keep the patient in treatment. It is important to mention that we did not expect DBT to have significant effects on depression, hopelessness or anger. We wanted to know whether DBT is effective in stabilising patients, in coaching them to gain control over emotions and impulsivity. In other words: to prepare BPD patients for 'normal' psychotherapy and to make it possible for BPD patients in the future to benefit from 'normal' psychotherapy.

The results of our study indicate that no consistent major differences between borderline patients with and without substance use problems in terms of clinical characteristics and etiological background can be traced. Substances abusing borderline patients do not seem to be more problematic than their non-substance abusing counterparts. Although the findings suggest that conflict avoiding BPD patients are referred to or select themselves into the mental health circuit, whereas antisocial BPD patients are more often found in the addiction treatment circuit, borderline patients with substance abuse problems could be found in both circuits. Our data, therefore, indicate that treatment allocation of BPD patients is the question, not the substance abuse itself. The exclusion of borderline patients with substance abuse problems from regular treatment services or from clinical trials, therefore, seems not justified.

We also found that the presence or absence of addiction problems and referral setting is not significantly associated with the individual's history of traumatic events, including childhood sexual abuse and PTSD. For DBT, the high comorbidity of Childhood Sexual Abuse and BPD has lead to the proposal to add a fifth module to the DBT skills training: attachment-building skills (Ciaramella, 2001). We hypothesised that comorbid substance abuse can be seen as 'chemical dissociation', i.e. substances are abused to achieve dissociative-like states as a substitute for 'true' psychological dissociation. Our findings did not support this hypothesis. Instead, we had to conclude that the levels of dissociation and PTSD among traumatised, substance-abusing
subjects were as high as those reported by their traumatised, non-substance abusing counterparts.

The results of the efficacy study support earlier findings by the founder of DBT. At 12 months, the dropout rate in the DBT group showed to be significant lower than in the control group, and significant stronger reductions of life-threatening and self-destructive behaviour for the DBT condition compared to TAU was found. This was especially true for the group of patients with the most severe symptomatology at base line.

At 18 months follow-up the findings indicated that the effect of DBT over TAU was retained for impulsive and self-mutilating behaviour. Also, an effect on alcohol abuse was found. The last finding seemed to be contradicted by the results of the analysis of the substance abuse data in the implementation article (chapter 6). There, at 18 months, no effect on substance abuse was found for DBT patients compared to TAU patients. One should be aware, however, of the fact that in the article about the implementation of DBT in a mixed population of substance abusing and non-substance abusing BPD patients, general abuse of substances was subject of research. The more detailed analysis of the 18 months data showed that DBT effected the alcohol abuse but not the abuse of hard drugs and soft drugs, a nuance that is of utmost importance for the interpretation of the conclusions of the implementation article. This article concluded that DBT is effective when the interventions are explicitly focused on specified behavioural domains, where on the other hand in other domains hardly any change occurs. Still our conclusion is that standard DBT should be the preferred treatment, eventually extended with specific modules, instead of developing a great number of DBT modifications. The results of the analysis of the 18 months data corroborate the usefulness of this viewpoint.

In conclusion, our research shows that DBT can be implemented in other settings. There is now substantial evidence that DBT is an excellent treatment for patients with severe BPD symptomatology (e.g., high-risk suicidal, self-damaging, and otherwise self-damaging behaviours), who were relatively resistant to change in standard or short-term treatments. We also know now that standard DBT is effective in the treatment of BPD patients who are comorbid with SUD. It could be hypothesised then also, that DBT could be expected to be effective for much broader indications like impulse control disorders, but much more research is needed to support such a hypothesis.
8.2 Limitations of the study

This is the largest RCT on DBT in the world so far. This is also the first RCT on DBT not conducted by the developer of the intervention. In general, the study was conducted with great care using high methodological standards. This is not to say that the study has no limitations or weaknesses. Overall, an important limitation is the sample size, and our findings therefore need replication. Because of the small sample size corrections for multiple testing could not be applied. Some of the statistical analyses should therefore, be considered exploratory. Accordingly, the findings should be considered with the necessary caution.

Another limitation is a consequence of the fact that the study on trauma used a cross-sectional design, based on retrospective self-report, implying temporal ambiguity of cause and effect. The correlational nature of findings precludes any firm conclusions.

The efficacy study was limited because the sample size was too small for studying three-way interactions; thus the analyses with respect to the possible efficacy and differential impact of substance use severity on DBT's efficacy should be regarded with some caution. Furthermore, the recommendation mentioned above, i.e. to develop multi-target DBT, is basically derived from indirect evidence. Future randomised trials are required to test the relative efficacy of that approach.

DBT was compared with 'treatment as usual' in the community rather than with some other form of experimental treatment. Ongoing treatment in the community as a control condition in randomised psychotherapy trials is a procedure recommended by others (e.g., Teasdale et al., 1984, Linehan et al., 1991), but it allows no conclusions about the experimental treatment's efficacy relative to other manualized treatment programs.

Substance use can contribute to problems of affective instability, impulsivity, and interpersonal problems (all core features of BPD). Many studies try to circumvent this potential confound by having patients report only those BPD traits that were present when not using substances. However, the reliability and validity of these retrospective reports still have to be demonstrated (Trull et al., 2000). Many of our subjects were still actively engaged in substance use during the study and our results can thus be influenced by ongoing substance use. However, we found a decrease in the use of alcohol in the DBT group compared to TAU. Our results, also, show significant decrease of impulsivity and of parasuicidal behaviour in the DBT group compared to TAU. The alcohol use then, compared to drug use, could function as an intermediate factor, decreasing impulsivity and thereby decreasing parasuicidal behaviour. However, the sample size of the current study did not allow testing this hypothesis.
The DBT patients were aware that they were participating in a new treatment. Positive expectations associated with this feature may have enhanced patient retention and other outcomes. Negative expectations and disappointments may have occurred for the control subjects, who were left with the traditional treatments they might have been trying to avoid through their request for participating in the research program. However, it is hard to imagine that these factors would have worked 12-18 months.

It remained unclear whether the control group received equivalent amounts of therapy, compared to the experimental group during the treatment phase. Every kind of treatment was possible according to the definition of 'Treatment-as-Usual': day hospital treatment, residential treatment, group treatment, outpatient treatment, and sole individual therapy. Even worse, 'Treatment as Usual' does not necessarily mean that psychotherapy was received or continued. This might have been an important factor because it has been found that in general troubled individuals who receive more psychotherapy improve more than those who do not (Lambert & Bergin, 1994).

We know that all control therapists were equally trained as clinicians compared to the experimental ones. The DBT therapists, however, received ongoing training in DBT in terms of team intervisitation and supervision, none of which was offered to the control therapists. DBT therapists therefore may have had greater enthusiasm and a resulting higher level of therapist motivation as compared to TAU therapists. As a consequence, differences in the quality of the working alliance could have been expected, influencing the final results of the efficacy study. Examination of the therapeutic alliance scores, however, indicated that the DBT and TAU conditions were highly similar in terms of scores on all subscales of the Working Alliance Inventory (Horvath & Greenberg, 1989).

Of course, a limitation could have been created because of the subjective nature of the measurements. We, however, used a sufficient amount of standardised instruments, which minimises this possible source of bias.

8.3 Clinical implications

8.3.1 Efficacy of standard DBT modules

Because we intended to replicate Linehan's original study, we had to use the DBT standard program, with an exclusively female population. Standard DBT is a manualized 12-month treatment that combines weekly individual cognitive-behavioural psychotherapy sessions with the primary therapist, weekly skills training groups lasting 2-2.5 hours per session, and weekly supervision and consultation meetings for the therapists (Linehan, 1993 a). Individual therapy focuses primarily on motivational
issues, including the motivation to stay alive and to stay in treatment. Group therapy teaches self-regulation and change skills, and self and other acceptance skills. Among its central principles is DBT's simultaneous focus on applying both acceptance and validation strategies and change strategies to achieve a synthetic (dialectical) balance in client functioning.

We found standard DBT to be efficacious in reducing borderline symptomatology for both substance abusing and non-substance abusing BPD patients. The findings corroborate those of another 13 studies investigating the effectiveness of DBT in patients with BPD (Table 1). DBT has been applied to a broad range of patient populations, including outpatient BPD patients, comorbid substance abusing BPD patients, inpatient BPD populations and juveniles and adults with antisocial behaviours. Nearly all these studies are discussed in two reviews (Koerner & Linehan 2000, Koerner & Dimeff 2000). Across studies, DBT seems to enhance treatment retention, reduce severe dysfunctional behaviours (e.g., parasuicide, substance abuse, and binge eating), and reduce psychiatric hospitalisations more than does either Treatment as Usual (TAU) or Treatment by Experts (TBE). These outcomes have typically been observed in samples of the more severely impaired borderline patients. The result with respect to levels of depression, hopelessness, and survival and coping beliefs, and overall life satisfaction is inconclusive with some studies reporting significant improvements (Linehan et al., 1991,1994; Bohus et al., 2000; Koons et al., 1998; McCan et al., 1996) and others not (Linehan et al., 1991, 1993; Stanley et al., 1998). These differences in outcome seem to be associated with the targeted problem areas: DBT seems to produce specific improvements in depression and hopelessness with less severe population of patients with BPD, while in the more severely impaired populations DBT reduces parasuicidal behaviour.

Based on the positive research results it can be concluded that one year of DBT is helpful but insufficient. A conclusion that DBT should be seen as the preferred intervention for all BPD patients is premature (Scheel 2000, Turner 2000, Levendusky 2000). Although there are several studies supporting the idea of DBT's superiority, the empirical base of the efficacy of standard DBT is still rather small. First, the number of randomised controlled studies with a reasonable sample size in which the standard program was examined is restricted to two, including the current study (Linehan et al., 1991; Verheul et al., 2002 [12 months]; van den Bosch et al., submitted [18 months]). Most studies have a non-randomised controlled design and an uncontrolled single group pre-post study design, which may suffer from serious selection bias. Even then, only four of them examined standard DBT (Bohus et al., 2000; Stanley et al., 1998; McCan et al., 1996; Shearin et al., 1992). Five studies hardly contribute to the empirical.

Another important limitation is that no direct comparison between DBT and other potentially effective approaches such as Psycho-Analytic Psychotherapeutic day treatment (PAP: Bateman & Fonagy, 1999), or Schema Focused Therapy (Young, 1990) are currently available. In addition, the question which elements of DBT (psychotherapy, skills training, phone consultation, therapist consultation team) make DBT an effective treatment method remains unanswered.
<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Design</th>
<th>Population</th>
<th>Treatment Condition</th>
<th>Type of DBT</th>
<th>Outcome/Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linehan et al., 1991, 1993a, 1994</td>
<td>Randomised controlled trial</td>
<td>Chronically suicidal women with BPD.</td>
<td>DBT n=24</td>
<td>Standard</td>
<td>Significant reductions in parasuicidal behaviour; significant higher retention rate; significant fewer inpatient hospital days. Results maintained throughout post treatment follow-up year. Less anger and better self-reported and interviewer-rated global social adjustment than TAU; lower psychotropic medication usage.</td>
</tr>
<tr>
<td>Linehan et al., 1999</td>
<td>Randomised controlled trial</td>
<td>Substance dependent BPD females</td>
<td>DBT n=12</td>
<td>DBT-S</td>
<td>Significant more reductions in drug abuse; significantly more retention, no differences on parasuicidal behaviour, amount of medical and psychiatric inpatient treatment.</td>
</tr>
<tr>
<td>Linehan et al., 2000</td>
<td>Randomised controlled trial</td>
<td>Opiate addicted women with BPD</td>
<td>DBT n=11</td>
<td>DBT-S</td>
<td>DBT subjects show better maintenance of treatment gains; CVT is superior in retaining subjects in treatment, no difference in incidence of parasuicidal behaviour; no between condition differences for incidence of psychiatric or drug related ER rooms and inpatient units visits.</td>
</tr>
<tr>
<td>*Linehan et al., 1998</td>
<td>Randomised controlled trial</td>
<td>Female suicidal BPD patients</td>
<td>DBT n=?</td>
<td>Standard</td>
<td>Reduction of suicidal behaviours, greater treatment retention, decreased use of psychiatric inpatient hospitalisation and emergency services.</td>
</tr>
<tr>
<td>*Koons et al., 1998</td>
<td>Randomised controlled trial</td>
<td>Female BPD veterans Inpatient</td>
<td>DBT n=10</td>
<td>Short DBT</td>
<td>More reduction in suicidal ideation, depression, hopelessness and anger. No differences in treatment retention.</td>
</tr>
</tbody>
</table>

Table 1: Research on DBT with BPD patients
<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Design</th>
<th>Population</th>
<th>Treatment Condition</th>
<th>Type of DBT</th>
<th>Outcome/Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linehan et al., 1993a,b</td>
<td>Non-randomised controlled</td>
<td>Chronically suicidal women with BPD</td>
<td>Outpatient</td>
<td>DBT n=11</td>
<td>DBT Skills training only</td>
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<td></td>
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<td></td>
<td>TAU n=8</td>
<td>Treatment outcomes not enhanced</td>
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<td></td>
<td></td>
<td></td>
<td>(individual without DBT skills training)</td>
<td>by adding DBT skills training group</td>
</tr>
<tr>
<td>Springer et al., 1996</td>
<td>Non-randomised controlled</td>
<td>Personality disorder</td>
<td>Inpatient</td>
<td>DBT n=16</td>
<td>Limited number of DBT skills</td>
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<td></td>
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<td></td>
<td>TAU n=15</td>
<td>included in creative coping group</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>(life style and wellness discussion group)</td>
<td>Subjects in the modified (DBT) group (creative coping) engaged in significantly more acting out behaviour during their hospital stay</td>
</tr>
<tr>
<td>Bohus et al., 2000</td>
<td>Non-randomised controlled</td>
<td>BPD parasuicidal females</td>
<td>Inpatient</td>
<td>DBT n=18</td>
<td>Standard DBT</td>
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<td></td>
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<td></td>
<td>TAU n=6</td>
<td>Significant decrease in number of parasuicidal acts; significant improvements in ratings of depression, dissociation, anxiety and global stress</td>
</tr>
<tr>
<td>* McCan et al., 1996</td>
<td>Non-Randomised controlled</td>
<td>Male forensic patients: 50% BPD. Psychosis no exclusion.</td>
<td>Inpatient</td>
<td>DBT n=21</td>
<td>Standard</td>
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<td></td>
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<td></td>
<td>TAU n=14</td>
<td>Significantly decreased maladaptive interpersonal coping styles, depressed and hostile mood, paranoia and psychotic behaviours. Trend toward reduction in staff burnout was reported</td>
</tr>
<tr>
<td>* Stanley et al., 1998</td>
<td>Non-Randomised controlled</td>
<td>Suicidal female BPD patients</td>
<td>Outpatient</td>
<td>DBT n=15</td>
<td>Standard</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>TAU n=15</td>
<td>(but shorter: 6 months in stead of 12)</td>
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<td></td>
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<td></td>
<td>Reduction in self-mutilation, behaviours, suicidal ideation and suicidal urges; no differences in self-reported psychopathology.</td>
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<tr>
<td>Author/Year</td>
<td>Design</td>
<td>Population</td>
<td>Treatment Condition</td>
<td>Type of DBT</td>
<td>Outcome/Results</td>
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<tr>
<td>Barley et al., 1993</td>
<td>Uncontrolled</td>
<td>No control group No control group</td>
<td>Total n=130</td>
<td>DBT skills training group was implemented</td>
<td>During three phases of integrating DBT onto unit outcomes were compared. Parasuicide rate lower following implementation of DBT.</td>
</tr>
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<td></td>
<td>Pre-Post</td>
<td>79% females All personality disorders</td>
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<td></td>
<td></td>
<td>Inpatient</td>
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<tr>
<td>* Miller et al., 1996</td>
<td>Uncontrolled</td>
<td>Suicidal teens, BPD or BPD features. 78% female</td>
<td>Total n=111 (most severe)</td>
<td>Modification of standard DBT for Adolescents (family therapy as needed)</td>
<td>Pre/post results within DBT group: significant decrease in suicidal ideation, global severity index and positive symptoms distress index; significant changes on SCL-90</td>
</tr>
<tr>
<td></td>
<td>Pre-Post</td>
<td>Inpatient</td>
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<td></td>
<td>Comparison</td>
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<tr>
<td>'CASE SERIES'</td>
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<tr>
<td>Shearin et al., 1993</td>
<td>Process study</td>
<td>Suicidal BPD female patients</td>
<td>N=4</td>
<td>Standard DBT</td>
<td>DBT additions to behaviour therapy (i.e., therapist giving autonomy and exerting control) is more associated with decreased suicidal behaviour than giving autonomy only (i.e., focus on acceptance) or exerting control only (i.e., focus on change)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inpatient</td>
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* These studies are unpublished till now and therefore cannot be regarded as controlled by peer-review.

This overview stresses the need for dismantling studies of standard DBT in the standard outpatient setting. Just a few small studies were carried out thus far (Linehan et al., 1993a; Linehan et al., 1998). Given the relatively high costs of DBT in terms of extensive training of therapists and duration/intensity of treatment, 'dismantling studies' are particularly promising in this regard. Such studies aim to investigate, for example, whether the individual component, the phone consultation or the protocolized attention given to the 'counter transferential phenomena' in the therapist consultation team, or a combination of all three, constitute DBT's efficacy in reducing self-harm. Knowledge about the specific mechanisms that make DBT work might direct the focus in treatment and stimulate further dismantling studies.
8.3.2 Efficacy of standard DBT: changes in BPD pathology

Our efficacy study, described in Chapter 5 and 6, demonstrates that DBT is more effective than TAU in reducing self-harm in chronically parasuicidal borderline patients, but that the impact of DBT in low-severity patients is similar to TAU. Combined with our findings showing that DBT is not more effective than TAU in inducing improvements in some other domains (e.g., levels of depression, hopelessness and overall life satisfaction), these findings suggest that DBT should be the treatment of choice only for chronically parasuicidal borderline patients. This interpretation is consistent with the original aims of DBT (Linehan 1987). An alternative explanation is that DBT is efficacious for patients with severe, life-threatening impulse control disorders rather than for BPD per se, implying that also some patients with other impulse regulation disorders (e.g., substance use disorders or eating disorders) might benefit from DBT. The latter interpretation is consistent with the development of modified versions of DBT for the treatment of BPD patient with comorbid diagnosis of drug dependence (Linehan et al., 1999) or patients with a binge-eating disorder (Wiser & Telch, 1999).

However, Linehan defines BPD as a disorder based on affective instability, not impulsivity (1993a). BPD can also be conceptualised as a lack of effective coping skills. Therefore, future research should address the question whether the favourable impact of cognitive behaviour therapies on the severity and frequency of parasuicidal behaviours in borderline patients, is indeed mediated by a strengthened ability to cope with life events through reassuring or self-soothing thoughts. This is one of DBT’s assumptions, next to the assumption that patients learn to cope better with impulsive deregulation through improved control over dysfunctional acting out. It is obvious that such a finding could have important implications for the focus of therapeutic strategies toward this group of patients.

We found no empirical support that affective pathology of patients with borderline personality disorder is improved by DBT. It should be noted here that we focused entirely on reducing the life and health threatening behaviour, with therapy-interfering behaviour coming second. The total DBT program distinguishes several stages of treatment. As mentioned in Chapter 1, the first stage is solely directed at reaching stability and control. Our treatment program was a stage one program. The individual patient in DBT treatment can only move to the second stage of treatment once behavioural control is achieved. The focus of the second stage is emotional experience and processing trauma from the past. As the results of our study show, most of our patients did not reach total behavioural control. Therefore, they could not get stage two treatment. This could drive us towards the conclusion that in this study the stage were changes in affect could have been focused on, was not reached. Therefore, changes in affect should not be expected. This is true for all studies on the effectiveness of DBT so far.
As a consequence, future research on DBT should also focus on stage two treatment, i.e. treatment after behavioural control has been reached. This seems to be supported by the results of the study of psycho dynamically oriented psychotherapeutic approach (e.g., Bateman & Fonagy, 1999). In a randomised controlled study, 38 BPD diagnosed men and women were assigned to either partial hospitalisation (based on PAP) or to general psychiatric services (control group). Bateman & Fonagy used similar inclusion and exclusion criteria as we did, but substance-abusing patients were excluded. The subjects of both studies were comparable in terms of base-line severity of BPD symptomatology. After six months of partial hospitalisation and PAP, improvement in psychiatric symptoms and suicidal acts occurred (i.e., behavioural control). At 18 months at the end of treatment patients showed significant improvement on both symptomatic and clinical measures, as well as in depressive symptoms. Follow-up data after 18 months showed that patients who completed the partial hospitalisation program not only maintained their substantial gains but also showed a statistically significant continued improvement on most measures (Bateman & Fonagy, 2001).

The results of the Bateman and Fonagy study seem to indicate that PAP is as effective or maybe even more effective than DBT, but there are some possibly influential differences between the PAP program and the DBT program, that need to be mentioned. First, the program is more intensified and extended than DBT. Activities in the PAP program include individual therapy, thrice weekly group analytic psychotherapy, expressive therapy, a community meeting, therapists supervision meetings twice a week, and partial hospitalisation. Activities in the DBT program consist of group skills training, individual psychotherapy, a therapist consultation team meeting once a week, and as needed phone consultation. This results in approximately 6½ hours of standard PAP therapy sessions for patients, in a day treatment setting, spread over 5 days (partial hospitalisation not included), compared to 3½ hours DBT for patients, spread over two days, in an outpatient setting. Therapists receive twice as much supervision in the PAP program compared to DBT. Also, the programs differ substantially in treatment duration: 18 months PAP versus 12 months in DBT. More important, however, is the question whether PAP can be as easily disseminated as DBT (Alper, 2001; Hawkins & Sinha, 1998; Barley et al., 1993), i.e. accepted and understood by clinicians of diverse backgrounds other than the developers of PAP. The fact that PAP is not protocollized can be a serious problem in this respect.

8.3.3 Efficacy of standard DBT: substance abuse

Two studies on DBT by Linehan focused on substance abuse. Using an extension of the DBT standard program (DBT-S), Linehan (1999) randomly assigned subjects meeting criteria for BPD and for a (poly) substance-use disorder (amphetamines, anxiolytics,
cocaine, cannabis, hypnotics, opiates, or sedatives) to DBT (n=12) or TAU (n=16) for 1 year of treatment. Alcohol abuse was not subject to this research. DBT-S was clearly effective in reducing drug abuse compared to TAU during the treatment year and at 1-year follow-up, but not in reducing borderline symptomatology such as parasuicidal behaviour. Specific training of DBT therapists in the additional substance abuse module was a prerequisite.

In 2002 Linehan published a study, in which Comprehensive Validation Therapy (CVT) with 12-Step was compared to DBT-S. Comprehensive Validation Therapy (CVT) with 12-Step is a manualized approach that provides the major acceptance-based strategies used in DBT in combination with participation in 12-Step programs. The patient group consisted of female BPD patients, who also had a diagnosis of current opiate dependence. They were assigned to DBT-S (n=11) and CVT+12S (n=12). It was found that both treatments, when combined with LAAM, were associated with reductions in opiate use relative to baseline, and in the maintenance of reduction during the 4-month follow-up period.

It should be mentioned also that there was a difference between conditions with regard to the maintenance of treatment gains. Subjects assigned to DBT-S showed better maintenance of treatment gains over 12 months of active treatment while those assigned to CVT+12S increased opiate use significantly during the last four months of treatment. No decrease was found with regard to other drugs including alcohol. By the end of the treatment year the level of drug use was similar to the level at baseline. CVT+12-Steps was more effective in maintaining subjects in treatment than DBT. Both groups showed at post-treatment and at 16-months follow-up significant overall reductions in the level of psychopathology as measured by the Brief Symptom Inventory (BSI, Derogatis & Melisaratos, 1983), global adjustment improvements and social adjustments ratings, but not in BPD symptomatology. Linehan’s study suggests that next to DBT-S other treatments can be effective in the treatment of opiate-dependent women meeting criteria for BPD. Unfortunately, no TAU comparison group was available, and therefore no firm conclusions can be drawn with regard to the effectiveness of each of the two treatments.

Our study, using standard DBT in a mixed population of BPD patients with and without SUD showed mixed results. Significant reductions in BPD symptomatology and alcohol abuse were observed in DBT compared to TAU, but no effects were seen in terms of reduced drug abuse (opiates, cocaine, cannabis) in DBT compared to TAU. The highly skewed distributions of the scores found, however, indicate that most of the research subjects showed just a low level of drug abuse, while a small sample can be characterized as severe BPD-SUD patients. This must have made it difficult to eventually find a differential effect. A study including more severe substance abusing BPD patients
as well as patients with severe BPD symptomatology is needed to reach conclusion about the effect of DBT on this population. A study that compares standard DBT with DBT-SS in a population of severe substance abusing BPD patients could be of great help here too.

We think it most plausible that DBT is a good, well-organised cognitive behaviour therapy, effective in reducing the problems that it is focused on. A DBT program for BPD patients, comorbid with substance use, then, should use a modified hierarchy of treatment goals. It could be hypothesised that substance abuse (drugs) should be prioritised first, next to or just below suicidal and self-damaging behaviours (including alcohol abuse) depending on its severity and influence on the capability of the patient to receive treatment; a conclusion that is shared by many authors (e.g., Links et al., 1995).

It is clear that further studies are needed in order to answer the question whether an integrated DBT program would be effective in treating BPD symptomatology as well as comorbid drug abuse.

It should be noted that all the studies mentioned here included only female patients. Therefore, more research is needed for BPD comorbid with substance abuse where gender issues are the focus. A study by Mercer (1997) showed that male and female addicted patients displayed some differences in symptoms and comorbid illnesses and thus may have different needs in treatment.

8.3.4 Efficacy of standard DBT: pharmacotherapy

The APA Practice Guideline (2001) provides an overview of the pharmacological treatments of BPD, and the research findings about the effectiveness of pharmacological interventions. It is remarkable how small the number of studies is, how small study populations are, and how few randomised controlled trials were conducted.

The conclusion of the overview is that there is almost no empirical support for most of the pharmacological treatments of BPD. There is some empirical support for neuroleptics in the treatment of broad-spectrum borderline pathology, including suicidality. MAO inhibitors can be used when there is deregulation of affect, impulsivity or aggression, or comorbid atypical depression. SSRI's are acceptable for the treatment of deregulation of affect. This is supported in a recent randomised controlled placebo controlled trial by Rinne (2002a) with female BPD patients, where the use of SSRI's significantly decreased affective instability, but not impulsivity and aggression. The Guidelines are clear that no benzodiazepines should be prescribed in case of behavioural disinhibition. Finally, there are some studies available that have examined symptom-focussed pharmacological treatment of BPD, such as dissociation (Schmahl
& Bohus 2001; Bohus et al., 1999). In conclusion, there is a very small empirical base for the pharmacological treatment of BPD.

In our sample 74% of the patients used prescribed medications from one or more of the following categories: 1) benzodiazepines, 2) SSRIs, 3) tricyclic antidepressants, 4) mood stabilisers, and 5) neuroleptics. Because potential treatment effects could be confounded by differences across conditions in the use of psychotropic medications, pharmacotherapies were monitored by repeated administration of the Treatment History Interview (THI) (Linehan & Heard, 1987). No major changes in the use of medications during the treatment year were observed. Although the borderline symptomatology was significantly reduced, nearly three quarters of the experimental group reported continued use of medication. Here the lack of a more controlled design for pharmacotherapy became clear.

In standard DBT, reducing medication is one of the treatment goals (Linehan et al., 1991). The positive effect of DBT on the reduction of medication use, or medical treatment episodes is reported in most of the research on DBT. It is remarkable that no study has required abstinence from benzodiazepines, when the use of drugs and alcohol is a common exclusion criterion. It is even more remarkable then, that no research has been conducted on DBT using a controlled design for pharmacological treatment like. This kind of research could give pharmacotherapy a more empirical base in the treatment hierarchy towards the goal of reaching stability and control.

Related to the issue of pharmacotherapy, the growing body of research on BPD in the neurobiological field seems very promising. Several studies have been reported on the role of neuro-transmitter systems in the development of impulsive-aggression and affective instability (e.g., Pally, 2002; Gurvits et al., 2000) and dissociation (e.g., Goodman et al., 2001). Also about the types of neurobiological impairments that can arise as a result of childhood sexual abuse and trauma (e.g., Driessen et al., 2000; Rinne et al., 2000), and the neurobiological impairment resulting from dysfunctional attachment and child maltreatment (Dimascio, 2002, Rinne et al., 2002b). This research is promising in that it provides new ideas on how to differentiate between different subtypes of BPD patients, and how to plan adequate pharmacological and psychotherapeutic support.

It is clear that results found in neurobiological and pharmacological studies cannot be generalised towards the other gender, for instance because of the differences in the serotonergic and the neuroendocrine system. At this moment, females are the most studied BPD patients with regard to psychosocial interventions, whereas most research on the effectiveness of pharmacological interventions has been undertaken in populations of men (APA Practice Guidelines, 2001). Therefore, the importance of pharmacological studies that differentiates between men and women needs to be emphasised.
8.4 Implementation: many problems and some solutions

The implementation of DBT seems always to be accompanied with problems (Swenson et al., 2002; Swenson et al., 2001). The unaccustomed character of the program, expressed in the attitude that is required towards patients and therapists of which the consultation-to-the-patient principle\(^2\) is the ultimate example, make it necessary to spend a lot of energy in the creation of a supportive atmosphere.

When our pilot study was ended, the results unexpectedly led to the financial support for a grant proposal by the largest health insurance company in Amsterdam. In the period of our pilot study, a group of researchers was preparing a large multi-centre study in the Netherlands in which three treatments would be compared: DBT, Psychoanalytic Therapy according to Kernberg and Yeomans, and Schema-Focused Therapy according to Young. Because of the awarded grant, and the time limit that was set by the insurance company, we decided to move quickly and not to wait till the other conditions would be ready to start. Instruments were translated as well as the skills training manual, diagnosticians were recruited and trained, therapists and trainers had to be found. This all took place in less than a year. However, because of the speed of our study, we lost the connection with the other researchers. The multi-centre study is not yet ended, but we know already that there is a difference between the other treatment conditions and DBT that will influence the findings. We did not demand substance users to detoxify first.

In our implementation trajectory we encountered difficulties in recruiting therapists because of 'phone consultation' in the DBT program. Therapists do not want to be 'on duty' for 24 hours, seven days a week. A lot of time and energy was spent trying to clarify the concept and its basis, to give reassurance ('they nearly don't phone at night') and to point out the importance (and opportunities) of the personal boundaries of the consultation agreement with the patient. However, we had to conclude that phone consultation is a serious problem when it comes to recruitment of therapists. We could not solve the problem in general, but were able to convince enough therapists to start a program, mainly because the experiences from the pilot period had shown that phone consultation seldom took place.

During the years of the study, therapists left and new ones had to be found. The strategy that worked best consisted of asking very experienced and well-known therapists in Amsterdam to join the team. They functioned as role models in the

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\(^2\) The primary task of DBT therapists is to advise their patients how to deal with their personal and social network, not to advise other professionals how to deal with their patients. Therapists are not allowed to talk about their patients or exchange patient information with other than their DBT colleagues who are part of the therapist consultation team.
consultation team, especially when dealing with the rare but very demanding problematic behaviours during phone consultations.

Another problem was a result of the fact that only a small portion of the group of therapists had any formal DBT training, and that their adherence rate for DBT was very low. Now it is clear that DBT can be disseminated and that DBT is easily accepted and understood by clinicians of diverse backgrounds, by personnel at all levels and by patients (Alper, 2001; Hawkins & Sinha, 1998; Barley et al., 1993). At the time of the start of the study, however, we thought it to be a problem to get the whole group trained. In addition, the education of DBT therapists had to include training in counselling techniques for substance abusers. It was decided that the leader of the team (LMCB) would supervise all therapists. It was also clear that just supervision would not suffice. Therefore two of the US trained DBT therapists (Dimeff and Shearin) were invited to give a two-day workshop. A special evening supervision group for the skills trainers was created. At a regular base supplementary training for all the therapists was organised and finally the need for training resulted in a three-day course in the fundamentals of DBT. The result was an average adherence rate of 3.8, range 2.5-4.5 (3.5-3.9 almost good DBT). In fact, we can conclude that although the therapy did leave some room for improvement, our results probably will not have been influenced by lack of treatment integrity.

Some of the main problems we faced during the study were a result of the way we chose to recruit patients. First, they had to get in contact with us, and then inform their therapist of their intentions, after which we informed the therapists on the research conditions. In addition, referring therapists were requested to formally agree with the study conditions, including both terminations of other treatments if the patient would be assigned to DBT and willingness to provide treatment-as-usual if not assigned to DBT. The patients had to stay in ongoing treatment during the research program. Even though we had the signed agreements of the therapists, it turned out that some of them, after receiving the result of the randomisation procedure, 'pushed' the patient out of therapy. For two patients this resulted in discontinued treatment while in the control condition. For these patients we found new control therapists.

Another problem had to do with the criteria we used as inclusion criteria for the study. Linehan (1991) had selected patients with 'recent parasuicidal behaviour'. We were afraid that this criterion would stimulate patients to engage in parasuicidal behaviour. Therefore, we dropped this criterion. The result was that our population did not show the same severity of dysfunctional behaviour as Linehan’s population. Nearly no suicide attempts were reported, in general few hospitalisations and a low number of days of inpatient care. As a result, in the statistical analysis the group needed to be divided in a group with high and a group with low severity BPD symptomatology.
Patients had to go through a battery of diagnostic tests and interviews, which took place in two days, within one week. Some tests proved to be a stressful experience for the patients. Especially some of the interviews (Lifetime Parasuicide Count, Trauma interview, RFL, SCID I and SCID II) asked a lot of the patients and diagnosticians. We trained the diagnosticians in a mix of validation (acknowledging the patients experiences) and motivational techniques (Miller & Rollnick, 1991), and to have an open mind for the problems of the patients during the diagnostic process. At a regular base brakes were offered with coffee and cigarettes; patients were cheer leaded through the session; alternative hours were introduced when patients needed a longer break (like planning an evening session) and patients were reoriented all the time towards the goal of this 'horrible' exercise. In between the two days the patients could phone the diagnosticians when they had questions about the diagnostics or felt bad about the process. All patients at baseline (n=92) finished the diagnostic process in two days. Within a week after finishing the diagnostic process, the diagnosticians went through the results with the patient and asked permission to send the report to the primary therapist. 13 patients were disappointed by the results because it showed that they could not be diagnosed as borderline patients. All patients, however indicated that although it had been hard to do, the interviews had given them insight in their problems, had solved the questions they had had about their 'illness'. In other words, what was feared to be an impossible task, turned out to be validation to patients.

Of course, attendance rate to the repeated measures could be expected to become a problem, especially because of the widespread conviction that BPD patients lack compliance and are not always motivated. It was clear that many patients, especially those belonging to the control group, were not motivated to come every three months. We thought that one way to solve this problem was, as said before, to make the diagnostic process as validating as possible. Other useful strategies were sending birthday and Christmas postcards, calling them a week in advance to confirm the appointment, finding other places to do the interviews when the patient did not want to come to the hospital and, finally giving them vouchers for showing up. More than 80% of the patients attended all assessment sessions.

Another problem worth mentioning was the enormous amount of patients trying to enter the program. It really seemed to be their last hope, and of course we were limited in our capacity. We decided not to use a waiting list, but to inform callers of the period in which they could present themselves. This worked. Of course we expected patients to be seriously disappointed when randomised for the control group. Two of them refused to go on with the project. One of them even threatened to commit suicide, but luckily changed her mind. What we did not expect was that patients would not agree to be placed in the experimental group. Two patients decided not to be part of the research because they wanted to stay with their (control) therapists.
For the information on the issue of 'consumption of care', necessary to examine cost-effectiveness, we relied on the subjective reports of the patients. This did not seem to create a problem because the insurance companies were willing to function as back up. They stated to have all the information with regard to hospitalisations, number of admissions and emergency room visits, but also of visits to general practitioners, prescribed medication etceteras. Unfortunately, after we finished the study it turned out that these companies could not deliver the information, due to problems in automatization. Therefore we had to rely on other sources. We checked the information given by the patients by phoning former therapists and hospitals, and in that way received confirmation on the dates.

Other problems to solve were connected with the place of the DBT project in Amsterdam. The treatment program consisted of therapists who spend an average of three hours each week with the DBT program (individual psychotherapy and consultation team time). Their normal jobs were with the hospitals they belonged to. The DBT program, therefore was emotionally not part of one of the hospitals, but 'floated' in the air high above Amsterdam and the institutions. As a consequence their was no back-up for the therapists except from the DBT team; there was sometimes considerably resistance from the hospitals and colleagues ('you should stop this hobby. Our patients need care too'); and the fear to be charged when a suicide would take place played an important role in the team. The answer to the problems was to analyse them and undertake effective action. So, we got in contact with the boards of the hospitals and got their agreement in accepting the patients of the individual therapists as patients belonging to their hospital. We gave a lot of talks in different settings, explaining what exactly it was we were doing, and how helpful DBT could be for the daily burden experienced by other professionals. Finally, directly contacting the state health inspection and asking them for advice in this situation solved the problem of the fear of being charged in case of serious adverse events. They stated that the structured and protocolized nature of DBT, and the way we were executing the treatment, was careful enough for the treatment of suicidal BPD patients and they concluded that the responsibility was taken good care of.

The research team was very small (less than two full-time equivalents). The team leader had to run the research project and treatment program in 0.2 of a full-time equivalent. In the beginning there was no statisticians engaged in the team, although individuals helped out. During the first months there was no one officially supervising the collection of data. There was no support where the organisation of workshops was concerned, especially with regard to the financial aspects of these activities. We succeeded in receiving a second grant, and discovered that by giving training to other professionals we could keep the program alive.
The last problems to mention were also connected to the organisation of the research project. The development of the research program had to be conducted so fast that some information that afterwards turned out to be important, like the data on consumption of health care, was not gathered in a systematic way. Also, it became clear during the study that much more care and attention should have been given to the control therapists. Enhancing their motivation to go on with the research, like for instance by giving them the opportunity to attend to a supervision group, was overlooked. As a consequence, it was difficult to make them return questionnaires or in other ways give information about the ongoing treatment.

We had financial resources till the moment the last measures were taken, at which moment the research team broke up. Processing the data had to be done by former research team members who spend their free time in performing the analysis, reviewing the articles. Without their help it would have been impossible to publish the results and show the efficacy of DBT. It is clear that further research would require a more stable financial base.

The problem that was feared most by all the team members, suicide, did not happen.

8.5 Developments after the study period

In a study with so many connections to the real treatment world, the question comes up what happened after the research program? Because of the preliminary data of the study that predicted support for DBT, and the vast amount of patients that asked to be accepted in the program, we had to come up with an answer to the question how to disseminate DBT into practice? A very important question was also how to motivate therapists to apply DBT. In the Netherlands, any therapist can take a new treatment and practice it in whatever way he or she chooses. We believe that individual therapists as well as community agencies in the mental health system need a deeper understanding of the character of BPD symptomatology and of the efficacy of DBT.

First of all this led to the development of DBT training possibilities by the author. A three-day training course was developed. Then the need of more thorough training emerged and a 10-day intensive training was created, modelled after the original one carried out by the BTTG (the Behavioural Technology Transfer Group in Seattle, the former Linehan training group).

Then it became clear that newly developing DBT programs needed and wished to receive team consultation and supervision. Especially the danger to develop a rigid attitude towards the application of DBT, because of the lack of trained sparring partners led to the conclusion that other therapists should receive the same level of training
as the author. A group of therapists went to Seattle. In 1999 Dialexis was founded, a centre for the development and implementation of DBT in the Netherlands.

In close co-operation with DBT/BPD patients the manual of the skills training was translated, and published in 1996. The textbook was translated and published in 2002. Practising DBT made clear that it answered a lot of questions about BPD treatment, but created sometimes even more. Therefore, articles were written about the implementation of DBT (van den Bosch et al., 1995; van den Bosch, 1998) and on DBT and client-centered therapy (van den Bosch, 2002). Also articles were published on DBT as an integrated therapeutic treatment method (van den Bosch, Linehan & Dimeff, 2001), and DBT and substance abuse (van den Bosch, 1996). In 2002 a book was published about the dos and don’ts of DBT (van den Bosch & Meijer, 2002). Training was given to German teams of therapists with regard to DBT and substance abuse, which also resulted in a publication (van den Bosch, 2001). A two-year project of training given by the author at the University of Geneva resulted in a DBT program and the translation of Linehan’s textbook in French (2000).

In the Netherlands and in Dutch speaking Belgium, a large number of lectures and one-day workshops were given. DBT was introduced and is now practised in Belgium. DBT became part of the training of psychotherapists, psychiatrists and nurses at a university level in the Netherlands, mainly to give them the opportunity to get acquainted to DBT and to develop a different attitude towards BPD and substance abuse.

The development of a network of former patients was supported and stimulated. Process groups came into existence, developed by ex-patients who decided to get consultation over skills because they needed it. A project in coaching families and relatives of patients was developed, which became integrated in an organisation for families.

The forensic psychiatric field came into focus and showed to have many BPD patients who were eager to enter a DBT program. DBT oriented programs were developed for forensic inpatient care, and for outpatient care, based on the idea that autonomy should be challenged as soon as possible (van den Bosch, 2003). Agreements were reached with the ‘normal’ health services in order to make residential crisis intervention as effective as possible. Even a module of team consultation was developed for programs with ‘difficult’ patients, oriented towards preventing burnout of therapists.

Some efforts were made to convince the co-ordinating organisation of the mental health services of the efficacy of DBT and its cost-effective character.

Time and again it became clear that continuous attention to the ‘DBT-character’ with new and existing programs and continuous and intensive training was necessary.
There were initiatives where DBT was reduced to (parts of) the skills training program, while the hospital called it a DBT program. The development of these programs can be understood when the pressure put on programs by the long waiting lists is taken into account. Also, the pressure coming from the fact that intakers have to deal with desperate, suicidal individuals will probably be a factor. On the other hand, the mental health services seem to be more interested in short and cheap treatments than in effectiveness. Of course, some of these programs had bad results, with a bad press for DBT as a consequence. The last years have shown an increase of partial DBT programs. Caution should be raised here, because as was pointed out in a study overview by Scheel (2000), partial or significantly revised versions of the treatment can lead to an opposite effect such as increased parasuicidal behaviour!!

8.6 Conclusions

The study made clear that one of the first requirements for good mental health care is a careful diagnostic process. As mentioned before, 13 out of 92 referred patients (14%) had to be excluded because they did not meet DSM-IV BPD criteria. All of our patients had been diagnosed as BPD during their years of contact with the mental health services. They received treatments and medications based on that diagnosis. It can be stated that adequate diagnostics are essential to patients in general and specifically to BPD patients.

We used standardised instruments and (semi) structured interviews to gather the information. The patients felt validated because of the attention paid to their problems. The examination, however, was based on the requirements of a research program, and took two days to go through. Perhaps this is too much for a normal mental health program, but we like to emphasise that the use of some instruments can prevent problems that can be very frustrating for therapists. For example, in one of the forensic programs the therapists were convinced that diagnostics were not necessary. Four out of nine patients, for years having been diagnosed as BPD patients, turned out not to meet the required number of criteria from the DSM-IV. A careful diagnostic process is also needed, because we know that female BPD patients are vulnerable to being victimised, especially when their problems are also combined with childhood sexual/physical abuse, substance abuse or PTSD (Butterfield et al., 1999, Giacalone, 1997). Studies focused on this topic suggest that the use of BPD as a diagnostic classification should be seriously reconsidered (Landecker, 1992; Yen & Shea 2001). The recent study of Rinne (2002b) showed that it is not the co-occurrence of the diagnosis PTSD that is of central importance here, but the occurrence of CSA/CPA.
We would suggest, that when BPD and CSA or CPA is present, a diagnosis Complex PTSD (Herman, 1993) should be used. This would provide recognition that a person's difficulties are associated with an abusive past and encourage a treatment approach that actually focuses on recovery from trauma and keeps patients from revictimization.

We like to stress how important it is to involve families of BPD patients in the treatment. Families struggle to deal with moods that swing from one extreme to another without any apparent provoking event, with what appear to be overreactions to incidents that seem minor, or with impulsive behaviours that may be dangerous. Families feel a sense of failure when efforts to improve or control situations in their homes go from increasingly more difficult to virtually impossible to manage. They pay a high price mentally and physically. The frustration of living with someone with BPD has ripple effect—from stress-related disorders to lost days of work, to marriages that don't survive. Across all disciplines, families are frequently blamed. No family should be expected to cope alone, yet very few support groups are available. Hoffman (1999) developed a family education curriculum based on DBT. The aim is to help families create a therapeutic environment that decreases stress and helps recreate trust. The biological basis of BPD is taught within a curriculum that emphasises validation techniques. Preliminary outcomes indicate that this course is extremely helpful to families.

We also like to stress how important it is to involve BPD patients with the treatment. Initially, in the Netherlands, consumer and family support groups were virtually non-existent. It seems to be a tradition of the mental health services to discourage patients and families from asking questions about diagnoses and treatment, or attending BPD research conferences. We are convinced that the more family members and patients know of the latest advancements, the better equipped they are to further the aims of researchers and clinicians. These people will build consensus in the community for implementation of BPD guidelines.

BPD is not a simple disorder and DNT is not an easy treatment to apply. In order to apply DNT, therapists and trainers need to get intensive training. Training is specifically required in order to prevent sex bias as pointed out before. Specialised training and considerable staff time are required if an intensive DNT treatment program is to be developed and maintained. It may well be that an intensive treatment program is critical to success with BPD and ultimately more cost-effective than 'revolving door' inpatient or outpatient services.

We want to emphasise this point. In the years since DBT has been implemented in the Netherlands it has become clear that mental health organisations seem to think that a single training should be enough. Although it is known that treatment of BPD patients...
involves the serious risk of transference and counter transference, and therefore the burnout of therapists, training, intervisio and supervision are still a target for budget cuts. The development of a DBT program however is expensive. For those who serve significant numbers of parasuicidal patients with BPD, dedicating the necessary resources for DBT might be justified. What we have seen in the Netherlands, however, are groups of patients too small to create a DBT program for. As a result, the hospitals allow patients to participate in the DBT program, who show some of the criteria of BPD but do not belong to the group of severe BPD patients for which DBT is effective, or even are not diagnosed as BPD. We would strongly suggest that the hospitals co-operate more when the treatment of chronically parasuicidal BPD patients is the focus. By combining scarce resources, the development of regional DBT centres could be of help.

This study has proven that it is possible to implement an effective treatment program for patients who are mostly seen as untreatable, unmotivated and manipulative, patients seen as impossible to create a therapeutic alliance with. With a very small amount of money and a handful of people a research program was carried out. More questions were raised than answered, but the relevance of the study for clinical practice is clear. DBT does reduce life- and health threatening, parasuicidal behaviours and keeps patients in therapy. Therapists feel more competent and supported and families are acknowledged for their efforts and pain.

Much more research is needed. We are convinced that the scientific and practising community has a responsibility to stop stigmatising persons with BPD. It is time to demystify BPD. We must set aside territorial issues and reach out to comorbid communities where our patients are hidden, blamed because of their problem behaviour but not being helped.

We must break down boundaries between disciplines and present comorbid conditions as themes and variations of syndromes to pave the way for innovative changes in mental health policy and treatment. Mental health, substance abuse and forensic services must unite their efforts, and bring the BPD patient into the light as a patient that can and wants to receive treatment, and a patient that can benefit from treatment.
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