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Towards optimal treatment for borderline personality disorder

Comparative effectiveness, treatment selection, and assessment

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Chapter 1

General introduction

BORDERLINE PERSONALITY DISORDER

Borderline personality disorder (BPD) is a severe and complex mental disorder. Although evidence-based treatments are available, important questions remain regarding their comparative effectiveness, cost-effectiveness, and optimal treatment selection for individual patients. To address these questions, the Borderline Optimal Treatment Selection (BOOTS) study was initiated and forms the basis of this thesis. This chapter first introduces the clinical characteristics and impact of BPD, then reviews current treatment and assessment practices, and concludes with the aims and outline of the thesis.

Clinical characteristics and diagnostic criteria

BPD is characterized by a pervasive pattern of instability in affect, identity, and interpersonal relationships, along with marked impulsivity (American Psychiatric Association, 2013). Individuals with BPD experience profound difficulties in regulating emotions, maintaining a coherent and stable sense of self, and sustaining healthy interpersonal relationships. In addition, BPD is marked by intense fear of real or perceived abandonment, impulsive behaviors (e.g., substance misuse, binge eating, reckless spending, risky sexual behavior), and recurrent self-harm and suicidal behavior. Chronic feelings of emptiness, intense anger, and transient stress-related cognitive disturbances, such as paranoid ideation or dissociation, are also common (Gunderson et al., 2018). Symptoms typically emerge in adolescence or early adulthood and are present across different contexts (American Psychiatric Association, 2013).

Historically, the term “borderline” was introduced by Stern (1938) to describe individuals who appeared to function at the boundary between neurosis and psychosis. The concept was further elaborated by Kernberg (1967), who emphasized primitive defense mechanisms and identity diffusion as central features. Gunderson and Singer (1975) subsequently contributed to the field by systematically reviewing the clinical literature to identify diagnostic criteria for BPD. BPD was formally recognized as a distinct diagnostic category in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III) in 1980 (American Psychiatric Association, 1980). In the current version of the DSM (DSM-5-TR; American Psychiatric Association, 2022), BPD is classified within Cluster B personality disorders and is defined by the presence of at least five out of nine diagnostic criteria (see Table 1).

Table 1. *Diagnostic Criteria for Borderline Personality Disorder*

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 following:

1. Frantic efforts to avoid real or imagined abandonment.
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance use, reckless driving, binge eating).
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior.
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

Note. Derived from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (American Psychiatric Association, 2022).

Epidemiology and burden of BPD

BPD represents a significant public health concern, with point prevalence estimates ranging from 1–3% in the general population (Ellison et al., 2018; ten Have et al., 2016) and lifetime estimates between 3–6% (Grant et al., 2008; Trull et al., 2010). Prevalence rates are substantially higher in clinical settings, with approximately 10% among psychiatric outpatients and up to 20% among psychiatric inpatients (Ellison et al., 2018; Zimmerman & Becker, 2023). Although prevalence rates in community samples show relatively small gender differences, women are overrepresented in clinical populations (Ramos-Suárez et al., 2026).

In addition to its high prevalence, BPD is characterized by marked clinical severity and substantial impairment across multiple life domains. BPD is associated with a high risk of suicide (2–5%, possibly up to 10%; Álvarez-Tomás et al., 2019; Paris, 2019), frequent suicide attempts or threats (> 75%; Black et al., 2004), and increased mortality (Kjær et al., 2020). Quality of life among individuals with BPD is markedly reduced, lower than in many common mental disorders and comparable to severe somatic conditions such as stroke and Parkinson's disease (Laurenssen et al., 2016). In addition, BPD frequently co-occurs with other mental disorders, including mood, anxiety, and substance use disorders, as well as with somatic health conditions, such as cardiovascular, endocrine, respiratory, metabolic, and sexually transmitted diseases (El-Gabalawy et al., 2010; Tate et al., 2022). Furthermore, individuals with BPD report severe impairments in interpersonal, occupational, academic, and financial domains, often exceeding the impairments observed in other personality disorders or major depressive disorder (Ansell et al., 2007; Skodol et al., 2002; Zanarini et al., 2010).

Beyond its impact on individuals with BPD, the disorder imposes a substantial economic burden on society. Individuals with BPD make extensive use of psychiatric and somatic healthcare services, including frequent and prolonged outpatient and inpatient psychiatric treatment, which results in significantly higher healthcare costs compared to other mental disorders (Bode et al., 2017; Laurenssen et al., 2016). In addition to direct healthcare costs, BPD is associated with considerable indirect costs, including productivity losses, unemployment, reliance on disability benefits, informal care, and out-of-pocket expenses (van Asselt et al., 2007; Wagner et al., 2022). Taken together, these findings underscore that BPD represents a severe mental disorder characterized by profound personal suffering and substantial societal costs.

TREATMENT OF BPD

Historically, BPD was widely regarded as a difficult-to-treat disorder (Sheehan et al., 2016). Over the past three decades, however, this perspective has shifted substantially, reflecting major advances in the development and empirical evaluation of specialized treatments for BPD. Psychotherapy is currently recommended as first-line treatment for BPD (Leichsenring et al., 2024), and meta-analytic evidence indicates that these approaches are more effective than treatment as usual or non-specialized interventions (e.g., Cristea et al., 2017; Oud et al., 2018; Stoffers-Winterling et al., 2022; Storebø et al., 2020). Among these specialized psychotherapies, Dialectical Behavior Therapy (DBT) and Schema Therapy (ST) represent two prominent approaches that are widely implemented in clinical practice. DBT is a comprehensive cognitive–behavioral treatment rooted in Zen, behaviorism, and dialectical philosophy, emphasizing emotion regulation through skills acquisition within a dialectical framework (Linehan, 1993). ST integrates cognitive–behavioral, experiential, developmental, and psychodynamic elements and aims to modify maladaptive schema modes and address unmet emotional needs (Jacob & Arntz, 2013; Young et al., 2006). These theoretical differences suggest distinct treatment targets and mechanisms of change.

Dialectical Behavior Therapy (DBT)

DBT, developed by Linehan (1993), is grounded in a biosocial model of emotion dysregulation, which conceptualizes BPD as the result of the interaction between emotional vulnerability and an invalidating environment. Building on this framework, DBT adopts a skills-deficit model, positing that maladaptive behaviors reflect dysregulated emotions or represent dysfunctional attempts to regulate emotions (Neacsiu et al., 2014). The treatment balances problem-solving strategies with validation within a dialectical framework, emphasizing the synthesis of acceptance and change. DBT aims to enhance patients' motivation for change, support the acquisition and generalization of skills, and address environmental factors when needed. In addition, DBT includes structured support for therapists to promote motivation and treatment adherence (Linehan, 2015).

DBT comprises four components: group skills training, individual psychotherapy, between-session consultation (telephone coaching), and team consultation for therapists. Group skills training targets behavioral skill deficits across four domains: mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance. Individual therapy emphasizes skills use in daily life and addresses motivational barriers. Treatment is organized into four stages. Stage 1 focuses on behavioral stabilization by targeting life-threatening behaviors, therapy-interfering behaviors, quality-of-life-interfering behaviors, and skill deficits. Stage 2 addresses posttraumatic stress, whereas Stages 3 and 4 aim to enhance self-respect, support the achievement of individual goals, and promote a sense of completeness. In practice, many patients do not progress to the later stages of DBT, and most research has primarily evaluated Stage 1 DBT (Wagner & Linehan, 2006). According to treatment guidelines, between-session consultation is provided, preferably by the individual therapist. In the BOOTS trial, between-session consultation ranged from availability during working hours to 24/7 telephone access, within limits set by the therapist. Finally, DBT therapists meet weekly in consultation teams to promote adherence and mutual support.

Schema Therapy (ST)

ST, developed by Young, is based on the concepts of early maladaptive schemas and schema modes (Young et al., 2006). Early maladaptive schemas are broad, pervasive patterns of cognitions, emotions, memories, and bodily sensations regarding oneself and one's relationships with others, typically originating from adverse childhood experiences and the frustration of core emotional needs (Young, 1999). A schema mode refers to the activation of specific schemas together with associated coping responses (surrender, avoidance, or overcompensation), representing the individual's momentary emotional, cognitive, and behavioral state. In the treatment of BPD, ST primarily relies on a disorder-specific schema mode model (Arntz & van Genderen, 2020), in which five schema modes are considered central to BPD: (1) vulnerable child mode, characterized by intense emotions, such as loneliness, fear of abandonment, and sadness; (2) angry and impulsive child mode, involving angry outbursts, hostility, and impulsive behaviors; (3) punitive parent mode, reflecting internalized critical or punitive voices and associated with self-criticism and self-punishment; (4) detached protector mode, marked by emotional detachment and avoidance strategies including withdrawal, dissociation, substance use, and self-harm; and (5) healthy modes, reflecting adaptive functioning (healthy adult mode) and the experience of fulfilled core needs (happy child mode), which are typically underdeveloped at the start of treatment (Kellogg & Young, 2006).

In the BOOTS trial, ST is delivered in a combined group–individual format developed by Farrell and Shaw (2012). The primary aim of ST is to reduce maladaptive modes, strengthen adaptive modes, and support individuals in meeting their core emotional needs. A central mechanism of change is limited reparenting, in which the therapist provides a corrective emotional experience within professional boundaries by offering a warm, active, and caring

"parent-like" relationship (Fassbinder et al., 2016). Experiential techniques, such as imagery rescripting and chair dialogues, are used to process emotionally charged memories and modify maladaptive modes, including the punitive parent mode. Cognitive and behavioral interventions include psychoeducation, restructuring of maladaptive schema beliefs, and behavioral pattern breaking (Kellogg & Young, 2006).

Comparative effectiveness of DBT and ST

Both DBT and ST have demonstrated effectiveness in the treatment of BPD (e.g., Arntz et al., 2022; Assmann et al., 2024; Setkowski et al., 2023; Storebø et al., 2020). However, the available evidence is generally of low to moderate quality (Stoffers-Winterling et al., 2022; Storebø et al., 2020), and ST has been studied less extensively than DBT. Moreover, direct head-to-head comparisons between specialized treatments are limited, despite their widely recognized relevance (Oud et al., 2018; Setkowski et al., 2023; Stoffers-Winterling et al., 2022; Storebø et al., 2020). While several BPD-tailored treatments have shown greater effectiveness than control conditions, these findings do not provide insight into their comparative effectiveness. Comparative trials are essential for advancing treatment options for individuals with BPD, facilitating informed clinical decision making, and guiding reimbursement and policy decisions (Assmann et al., 2024).

To date, only one randomized clinical trial (RCT) has directly compared DBT and ST (Assmann et al., 2024). Both treatments yielded substantial improvements across multiple domains. In general, no significant differences were observed between DBT and ST across most outcomes, except for DSM-5 BPD criterion 8 (anger), for which DBT demonstrated superiority. Additionally, retention rates did not differ at the end of treatment, although patients receiving DBT tended to drop out earlier than patients receiving ST. However, the study was conducted in a single tertiary outpatient setting specifically for patients with severe BPD who frequently require emergency care or inpatient treatment. Both the single-center design and the focus on severely affected patients limited the external validity of the findings. The authors therefore emphasized the need for further comparative trials.

Regarding cost-effectiveness, direct comparisons between DBT and ST are currently lacking. Reviews indicate that psychotherapy is generally cost-effective for personality disorders, including BPD, and associated with decreased healthcare costs (Meuldijk et al., 2017; Wetzelaer et al., 2016). While individual ST has demonstrated cost-effectiveness (van Asselt et al., 2008), the cost-effectiveness of combined individual–group ST has yet to be established, despite its widespread implementation in clinical practice. Economic evaluations of DBT generally support its cost-effectiveness (Krawitz & Miga, 2019), but considerable methodological variability exists and the number of available trials remains relatively small (Brettschneider et al., 2014; Krawitz & Miga, 2019; Meuldijk et al., 2017). Moreover, concerns have been raised regarding the methodological quality of economic evaluations

of BPD treatments (Murphy et al., 2020; Wetzelaer et al., 2016), and direct comparisons of evidence-based treatments are scarce (Krawitz & Miga, 2019). This is noteworthy, given that economic evaluations provide essential information for resource allocation decisions.

Taken together, rigorous comparative evaluations of the clinical and cost-effectiveness of DBT and ST are urgently needed. The BOOTS study directly addresses this gap by examining both clinical and economic outcomes.

TREATMENT SELECTION IN BPD

While head-to-head trials are essential for establishing comparative clinical and economic effectiveness at the group level, average treatment effects provide only part of the picture. Demonstrating that one treatment performs better than another on average does not reveal which treatment is most effective for which patients. It has long been recognized that treatment effects may vary across individuals, with treatments considered broadly effective sometimes proving ineffective or even harmful for certain individuals (Chekroud et al., 2021; Meinke et al., 2024; Sverdrup et al., 2025; Woodbridge et al., 2021). Moreover, when multiple interventions are available, their relative effectiveness may differ between patients (Velentgas et al., 2013). To improve outcomes and reduce societal costs, treatment selection must therefore move beyond the question of whether an intervention works on average toward understanding for whom and under which circumstances it works best.

In clinical practice, selecting the optimal treatment for each patient is a daily task for clinicians, yet there is limited empirical evidence to guide these decisions. Consequently, treatment allocation for patients with BPD is largely based on clinical judgment. However, there is ample evidence that clinical judgment is suboptimal compared to actuarial methods (Ægisdóttir et al., 2006; Grove et al., 2000). Selecting the most appropriate treatment for an individual patient is inherently complex and susceptible to various biases, making decisions based primarily on personal experience and beliefs highly prone to error (Denig et al., 2002; Gottfredson & Moriarty, 2006). This challenge may be particularly pronounced in BPD, as the disorder is characterized by substantial heterogeneity in its manifestations (Bohus et al., 2021; Gunderson et al., 2018; Leichsenring et al., 2024). Co-occurring conditions, such as substance use disorders (Zanarini et al., 2004), may further influence treatment response. Given the complexity and heterogeneity of BPD and the range of available BPD-tailored treatments, it is plausible that individuals with different constellations of symptoms and vulnerabilities may respond differently to specific treatments (Setkowski et al., 2023). Emerging evidence indeed suggests the presence of heterogeneous treatment effects in psychotherapy for BPD (Kaiser & Herzog, 2023). Identifying patient characteristics associated with differential treatment response may therefore offer a promising avenue for optimizing treatment selection among individuals with BPD (Keefe et al., 2021).

Predictors of treatment response

Historically, attempts to predict psychotherapy outcomes have primarily focused on single variables, which have demonstrated limited explanatory power (Chekroud et al., 2021; Zilcha-Mano, 2019). More recently, multivariate approaches, including machine learning (ML) techniques, have been applied to predict treatment response (Rutledge et al., 2019). These methods offer a flexible framework capable of modeling complex, potentially nonlinear relationships and integrating large numbers of predictors (Aafjes-van Doorn et al., 2021). To date, multivariate ML approaches have been predominantly investigated in mood disorders (Aafjes-van Doorn et al., 2021), with limited research conducted in BPD. Nevertheless, the available evidence appears promising. For example, certain baseline characteristics have been associated with differential response to DBT versus General Psychiatric Management (Keefe et al., 2021). In a comparison of DBT and ST, a specific combination of patient characteristics (emotional neglect, sexual abuse, anxiety symptoms, functioning, and the "failure to achieve" schema) predicted more favorable short-term outcomes in DBT, whereas no consistent predictors favored ST, and these effects did not persist at follow-up (Assmann et al., 2025).

At the same time, important limitations remain. Many studies rely on a single modeling strategy, despite evidence that no predictive approach is universally optimal (Giesemann et al., 2023; Webb et al., 2020). Moreover, because predictor analyses are typically conducted within RCTs primarily designed to assess overall treatment effectiveness (Kessler, 2018), variables relevant to differential treatment response may not have been systematically assessed (Arntz et al., 2015; Spinhoven et al., 2008). The performance of statistical models depends critically on the availability of informative predictors. As noted by Meehl (1954), actuarial prediction methods will not outperform clinical judgment when statistical models are based on inadequate knowledge of relevant variables. Westen and Weinberger (2004) argue that clinical expertise may play an important role in identifying relevant candidate predictors that can be incorporated into predictive models. These considerations underscore the importance of including a comprehensive set of predictors informed by both theory and clinical expertise when investigating differential treatment response.

Against this background, the BOOTS study offers a unique opportunity to compare DBT and ST at the group level while also exploring clinically meaningful heterogeneity in treatment response. By integrating extensive baseline assessments with a comprehensive multivariate modeling approach, the BOOTS study provides a framework for advancing personalized, evidence-informed treatment selection in BPD.

ASSESSMENT IN BPD

Beyond questions of effectiveness and treatment selection, rigorous assessment of BPD and treatment-related processes plays a crucial role in advancing both research and clinical

practice. The validity of conclusions about diagnosis, treatment effects, treatment allocation, and underlying mechanisms depends on the quality of the instruments used. The selection of assessment instruments therefore requires careful evaluation of their psychometric properties, intended purpose, and practical feasibility in research and clinical contexts.

Screening and outcome assessment

Accurate identification of BPD is essential for both clinical care and research. However, BPD is frequently misdiagnosed or underdiagnosed, which may be related to its heterogeneity, high comorbidity rates, and clinicians' hesitation to assign the diagnosis (Comtois & Carmel, 2016; Culina et al., 2023; Zimmerman et al., 2010; Zimmerman & Balling, 2021). Semi-structured diagnostic interviews are widely regarded as the preferred method for diagnosing BPD (Bohus et al., 2021; Gunderson et al., 2018; Leichsenring et al., 2024), yet they are time-consuming, costly, and require substantial clinical expertise (Bloo et al., 2017). Moreover, diagnostic interviews typically assess symptoms over extended periods and are not designed to detect changes over shorter time frames, rendering them less suitable for repeated outcome assessment (Bloo et al., 2017). As a result, self-report questionnaires are frequently used for screening and outcome assessment.

Several self-report instruments have been developed to assess BPD symptomatology, including the BPD Checklist (Bloo et al., 2017), the Borderline Symptom List (Bohus et al., 2009), and the Personality Assessment Inventory-Borderline Features scale (Morey, 1991). Although these instruments demonstrate adequate psychometric properties, their length may limit their feasibility in settings that require repeated assessments, as longer self-report instruments have been associated with increased perceived burden, lower compliance, and careless responding (Eisele et al., 2022; Hoerger, 2010; Rolstad et al., 2011). Brief instruments are available, but most have been developed primarily for screening purposes. The McLean Screening Instrument for Borderline Personality Disorder (MSI-BPD; Zanarini et al., 2003) is among the most widely studied screening tools for BPD. However, screening instruments also present notable limitations, including recommended cutoff scores that have yielded suboptimal sensitivity (Zanarini et al., 2003; Zimmerman & Balling, 2021) and the use of categorical response formats, which contrast with evidence supporting the dimensional nature of BPD and may limit sensitivity to change (Arntz et al., 2009; Zimmerman et al., 2013). These considerations highlight the importance of psychometrically sound and feasible instruments for assessing BPD symptoms over time. At the same time, evaluating treatment in BPD requires reliable assessment of both outcomes and the processes underlying therapeutic change.

Treatment-related processes

Whereas outcome measures indicate *whether* individuals improve, process measures are required to elucidate *how* such improvement occurs. Investigating mechanisms of change helps clarify the core ingredients of treatments and refine theoretical models, which may

in turn improve treatment efficiency (Zilcha-Mano, 2019). Research on change processes in BPD treatment has increased substantially over recent decades, although most trials have primarily focused on outcomes rather than on the mechanisms underlying therapeutic improvement (Forster et al., 2014; Orlinsky et al., 2004). Emerging evidence suggests that specific mechanisms may underlie treatment effects in BPD, including mechanisms proposed in DBT (e.g., emotion regulation, skills use; Rudge et al., 2020) and ST (e.g., schema modes, maladaptive beliefs; Yakın et al., 2020). The literature nevertheless highlights the need for more rigorous empirical research to evaluate proposed mechanisms of change in treatments for BPD (Aafjes-van Doorn & Barber, 2018; Rudge et al., 2020).

Advancing this domain hinges on the availability of psychometrically sound instruments to assess treatment-related processes. In DBT, skills use has been proposed as a central mechanism of change (Neacsiu, Rizvi, & Linehan, 2010). Evidence supporting the mediating role of skills use is accumulating, but research has historically been constrained by the limited availability of instruments specifically designed to assess DBT skills use (Neacsiu, Rizvi, Vitaliano, et al., 2010). The development of the DBT Ways of Coping Checklist (DBT-WCCL; Neacsiu, Rizvi, Vitaliano, et al., 2010) addressed this gap. However, until recently, no translated and psychometrically validated version was available for Dutch-speaking populations, limiting its use in research and clinical practice in the Netherlands. This underscores the need for accessible, validated measures in BPD.

Taken together, rigorous measurement of both outcomes and treatment-related processes is essential for advancing research and clinical practice in BPD. Within the context of the BOOTS study, several instruments were developed and evaluated, thereby contributing to the continued refinement of assessment methods in BPD.

AIMS AND OUTLINE OF THE THESIS

This thesis is based on the BOOTS study, a multicenter RCT comparing DBT and ST among outpatients with BPD, designed to address the question: “Which treatment, DBT or ST, works best for which individual with BPD, and why?”. The overall aim of this thesis is to contribute to the optimization of treatment outcomes for patients with BPD within the context of the BOOTS study by (1) evaluating the clinical and economic effectiveness of DBT and ST, (2) advancing personalized treatment selection through prediction of differential treatment response, and (3) strengthening assessment in BPD research and practice. The present thesis comprises eight studies organized into four parts, each consisting of two chapters. The first part provides the methodological and clinical background of the BOOTS study, whereas the subsequent parts address the three main aims of the thesis.

The first part, entitled "**Design and rationale of the BOOTS study**", includes two chapters that establish the methodological framework and scientific rationale of the BOOTS study. **Chapter 2** presents the study protocol of the BOOTS trial, outlining the design of the multicenter superiority RCT, treatment conditions, measures, and planned statistical analyses. The study protocol provides the foundation for the empirical studies presented in the subsequent chapters. **Chapter 3** provides a comprehensive evaluation of the burden of disease associated with BPD by examining quality of life using both a generic and a mental health-specific measure and by estimating annual costs from a societal perspective.

Part two, titled "**Comparative treatment effectiveness**", comprises two chapters evaluating the clinical and economic outcomes of DBT and ST within the BOOTS study. **Chapter 4** examines the relative clinical effectiveness of DBT and ST among outpatients with BPD. Both treatments were delivered over a 2-year period in a combined group–individual format, with outcomes assessed up to 3 years after baseline. In addition to BPD severity as the primary outcome, the study evaluated secondary outcomes across multiple domains, including general psychopathology, psychosocial functioning, well-being, and treatment retention. **Chapter 5** extends this comparison by conducting an economic evaluation of DBT versus ST from a societal perspective over a 3-year time horizon. This chapter includes both cost-effectiveness and cost-utility analyses.

Part three, labeled "**Personalized treatment selection**", focuses on advancing personalized treatment selection and examining treatment effectiveness across clinically relevant subgroups. **Chapter 6** investigates predictors of differential treatment response to DBT versus ST among outpatients with BPD using data from the BOOTS study. A comprehensive ML modeling approach was applied to identify patient characteristics associated with differential treatment dropout and treatment response, and the potential clinical utility of model-informed treatment allocation was subsequently explored. **Chapter 7** examines whether a comorbid substance use disorder (SUD) influences treatment outcomes in BPD. This secondary analysis of the BOOTS study compares clinical, psychosocial, and substance use outcomes in patients with and without comorbid SUD, thereby assessing the suitability of DBT and ST for this subgroup.

The final part of the thesis, "**Assessment**", concerns the psychometric evaluation of instruments used to assess BPD symptoms and treatment-related processes. **Chapter 8** presents a comprehensive psychometric evaluation of the Ultrashort BPD Checklist (uBPDc), a brief instrument developed for efficient screening and outcome assessment in BPD. **Chapter 9** evaluates the Dutch version of the DBT Ways of Coping Checklist (DBT-WCCL), an instrument designed to assess DBT skills use and dysfunctional coping, thereby contributing to the assessment of treatment-related processes in DBT. The thesis concludes with a general discussion of the key findings, methodological strengths and limitations, and clinical and research implications in **Chapter 10**, followed by a summary.

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