

Outcome of Psychoanalytically Oriented Outpatient Treatment of Borderline Personality Disorder: A Pilot Study¹

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This study examines the outcome of up to fifteen months of psychoanalytically oriented psychotherapy (primarily based on object relations and attachment theory) for patients with borderline personality disorder. Nineteen patients with borderline personality disorder, diagnosed by an experienced psychiatrist as part of the general clinical evaluation, were offered two years of treatment in an outpatient setting. Treatment included individual psychoanalytic psychotherapy, psychoanalytic group therapy, and group-based psychoeducation. Outcome was measured with a battery of self-report questionnaires: the Beck Anxiety Index (BAI), the Beck Depression Inventory (BDI), and the Symptom Check-List (SCL-90-R). Analyses focused primarily on the first fifteen months of treatment. The dropout rate was relatively high, but patients who remained in treatment (N=11) reported statistically significant positive changes in levels of anxiety and depression and general level of functioning. We found no significant differences between the group of patients who remained in treatment and those who dropped out. Follow-up data for up to 32 months indicated not only that the positive changes observed were maintained, but that patients who completed at least fifteen months of treatment reported additional improvements in the follow-up period.

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Borderline personality disorder represents a substantial public health problem. Since the introduction of personality disorders on a separate axis in the DSM-system, borderline personality disorder has been studied more intensively than any other. The prevalence of borderline personality disorder in the general population is at least 1% (Mattia & Zimmerman 2001) and it affects more than 10% of patients in psychiatric care. The disorder is persistent and accompanied by severe subjective distress, chronic instability in multiple areas (emotional dysregulation, impulsivity etc.), identity disturbance (Jørgensen 2006b), frequent acts of self-

1 Rikke Bøye, Charlotte Freund, Ingelise Funk, Lise Larsen and Merete Sandahl have contributed to the study as psychotherapists or assessment interviewers.

mutilation, a high suicide rate (up to 10%), significantly reduced levels of functioning over long periods of time, often years, and a broad range of severe social problems (unemployment, lack of formal education, poverty, social isolation, etc.). Psychotherapy is the most widely practiced method for treating borderline patients but because of scepticism about the effectiveness of treatment and pessimism about prognosis in general the care of patients with borderline personality disorder is often neglected. Recent meta-analyses (Leichsenring & Leibing 2003, Bateman & Fonagy 2000, Perry et al. 1999) have concluded that psychotherapy in general is an effective treatment for personality disorders, including borderline personality disorders, and that specialized psychotherapy is superior to the natural course of the disorder or control treatments. The typical borderline patient is a frequent user of the health care system and studies (Bateman & Fonagy 2003b, Stevenson & Mearns 1999, Gabbard et al. 1997) have suggested a substantial long-term cost benefit from appropriate (intensive, focused and specialized) psychotherapeutic treatment of borderline patients.

In the last decade three by now widely acknowledged models of treatment have been developed: transference-focused psychotherapy (TFP) (Kernberg et al. 1989, Clarkin et al. 2006), mentalization-based treatment (MBT) (Bateman & Fonagy 2004) and dialectical behaviour therapy (DBT) (Linehan 1993). In addition to these models, specialized group-treatment (Marziali & Munroe-Blum 1994) and family therapy (Gunderson et al. 1997) have been introduced. Treatment manuals are available for TFP, MBT and DBT and the efficacy of DBT and MBT especially is supported by relatively few, but generally acknowledged, randomized studies (Linehan et al. 1991, 1993, 1994, Bateman & Fonagy 1999, 2001). Two studies partially support the efficacy of TFP (Clarkin et al. 2001, Giesen-Bloo et al. 2006). Long-term outcome of the three models is still largely unknown and an important and still unanswered question concerns how easily and to what extent these relatively complex treatment programs can be disseminated – i.e. understood, accepted, and competently implemented – by clinicians from diverse backgrounds and in clinics with limited resources. In general, we have insufficient evidence as to whether the demonstrated outcome of these treatment models under relatively controlled conditions can be generalized to the clinic.

Study Design

This primarily naturalistic study was conducted at the Clinic for (Borderline) Personality Disorders which is part of the Psychiatric Hospital in Aarhus County, Denmark. The aim of the study was to examine the effectiveness of long-term psychoanalytic psychotherapy for borderline personality disorder as it occurs in daily clinical practice. As a consequence of the naturalistic design the external

(clinical) validity of the study is relatively high, without severely compromising the internal (scientific) validity.

All admitted patients (N=19) were offered two years of psychoanalytically oriented psychotherapy in an outpatient setting that specialized in the treatment of patients with borderline personality disorder.

Patients

Patients were referred from psychiatric wards, outpatient clinics and general practitioners in Aarhus County. Potential subjects were screened with a series of (2-3) clinical interviews conducted by three psychiatrists: an experienced psychiatrist (second author) and two less experienced psychiatrists under the close supervision of the experienced psychiatrist. All patients were diagnosed according to DSM-IV-TR criteria for borderline personality disorder. The clinical interviews also provided information for rating the patient's Global Level of Functioning (GAF) and were used to diagnose co-morbid psychopathology. Only those patients who met the diagnostic criteria for borderline personality disorder (301.83, DSM-IV-TR) and were between 21 and 50 years were admitted. Patients who met the diagnostic criteria for schizophrenia, bipolar disorder, organic disorder, schizotypal, schizoid or dissociative personality disorder were excluded. Additionally, patients with severe substance abuse and patients with a Global Assessment Score (GAF) below 35 were excluded. On entering the treatment, more than half (68%) of the patients were on some form of (mainly anti-depressant) medication and a substantial proportion of the patients were overmedicated according to APA-recommendations (Oldman et al.2001). These medications were slowly reduced for approximately half of the patients (n=8), in some cases (n=6) the medications were withdrawn. For ten of the patients, medications remained basically unchanged throughout the treatment period. In the first part of the study, the clinic was under construction and thus not fully established. The nineteen subjects in the study were admitted to treatment consecutively and represented the first group of patients with borderline personality disorder who had been referred to the clinic and accepted the conditions of the study. In the intake period no borderline patients who met the inclusion criteria were rejected and all referred borderline patients agreed to participate in the study. Written informed consent was obtained after all study procedures had been explained and the patients had received a written description of the study. The study was approved by the research ethics committee of Aarhus County. Essential demographic and clinical characteristics at intake (assessment) are listed in Table 1.

Characteristic	Mean	SD
	Age	28.3
GAF-score (N=19)	45.0	5.6
IIP-total-score (N=16)	1.7	0.5
	N	%
One or more PD other than BPD	6	32
Depression	12	63
Anxiety disorder	3	16
Female sex	16	84
Single	6	32
Married/Partner	6	32
Several Successive partners	7	37
Education and work:		
Elementary school	3	16
High School graduate	11	58
Professional	3	16
Academic degree	2	11
Student	8	42
Employed	1	5
Successive short-term employments	5	26
Social security/pension	5	26
Trauma and self-destructive behaviour:		
Reported self-mutilating behaviour	10	53
Reported history of suicide attempts	5	26
Reported sexual abuse	5	26
Drug-treatment:		
Anti-depressive drug-treatment	11	58
Anti-psychotic drug-treatment	5	26
No drug-treatment	6	32

Table 1. Demographic and clinical characteristics at intake (assessment) of borderline patients who received psychoanalytically oriented outpatient treatment (N=19)

Eleven patients completed at least fifteen months of treatment, while eight patients (42%) dropped out within the first fifteen months. This is a relatively high dropout rate but in contrast to other studies (e.g. Bateman & Fonagy 1999) we included in our analyses all patients who intended to start treatment; thus patients who regularly refused more or less explicitly to answer self-report questionnaires were not excluded from the study. After fifteen months of treatment, one of the therapists (a clinical psychologist who was the primary therapist for five patients) went on maternity leave. This was the main reason for at least three dropouts in the following 15-18-month treatment interval. All patients were referred to an alternative therapist, but most of them either rejected the offer or dropped out of treatment shortly afterwards. Because of the substantial increase in the attrition rate 15-18 months into the study, the main focus of the present report is on the outcome of the first 15 months of treatment. Four patients (21%) completed the full two-year treatment. Some of the patients occasionally refused to answer the outcome questionnaires. Developments in the attrition-rate and reported reasons for dropout are listed in Figure 1.

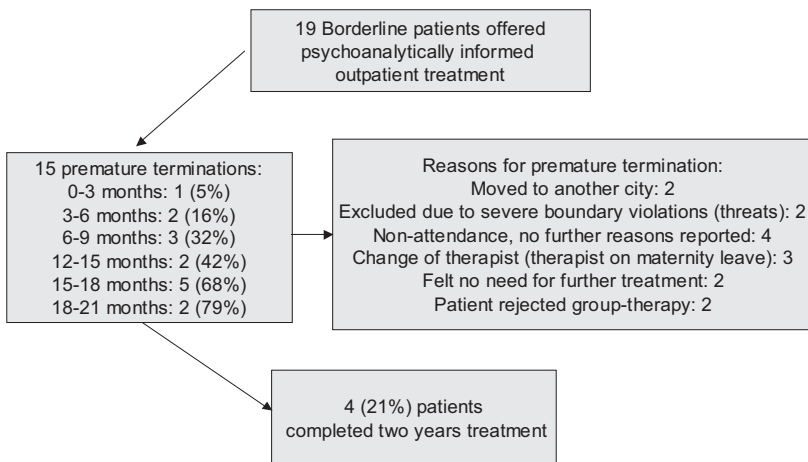


Figure 1: Time and Reported reasons for drop-out from the study

The group of patients who completed at least fifteen months of treatment were followed for up to two and a half years. Some more or less explicitly refused to participate in the follow-up study and we did not try to prevent these patients from having further or alternative treatment in the follow-up period. Follow-up data were collected for eight patients at 24 and 32 months.

Treatment and therapists

All admitted borderline patients were offered two years of multifaceted and structured treatment based on psychoanalytic principles. Elements from other treatment modalities (psychoeducation) were also included. The treatment offered consisted of (1) weekly individual psychoanalytic psychotherapy for 12 months, (2) weekly group analytic psychotherapy (one and a half hours in closed groups with 6-7 members) for 22 months, and (3) group-based psychoeducation once a week for two months. In terms of theory, the treatment was based primarily on the independent group of object relations theory (Guntrip 1961, Winnicott 1971) and on core elements from attachment and mentalization theory, as described by Bateman & Fonagy (2003a, 2004). The treatment emphasized the relational aspects of borderline disorder and how the relational problems of these patients are linked to object relationships and failures in the ability to mentalize. Both supportive and more expressive elements were included (Gabbard 2000). Genetic interpretations and complex interpretations of the transference as a repetition or displacement from the past were not used. Transference was used only as a demonstration of alternative perspectives on present experiences. Inspired by the work of Gunderson (2001), the goal of the first months of treatment was to engage the patient in treatment. After this, the primary goals were to develop and deepen the therapeutic alliance, change maladaptive behaviours, develop the patient's ability to mentalize, and enhance his/her ability to be in emotionally engaging relationships (positive dependency).

The therapists helped the patients to identify and differentiate their emotions and other mental states in the here-and-now. Attention was given to the patient's maladaptive defences and attempts to protect the self. The therapists recognized and sought to verbalize the (once adaptive) psychological functions of these defences and other attempts to regulate the self, and to show how defences were manifested in the present. Finally, the understanding of the patient-therapist interaction (transference and counter-transference) was inspired by Kernberg's ego-psychological object-relations model (Kernberg et al. 1989, Clarkin et al. 1999). The recapitulation of dominant object-relation patterns and maladaptive relational patterns in the patient's here-and-now experience of and interaction with the therapist was identified and put to therapeutic use as part of the overall endeavour to develop the patient's ability to mentalize (Jørgensen 2006a).

Group therapy was conducted by highly experienced group therapists and specifically targeted the core problems of severe borderline personality disorder. The therapists actively contributed to the regulation of individual feelings, impulses and mental states and intervened when conflicts arose between the group members. In order to enable the group members to work therapeutically, anxiety-pro-

voking silences were avoided and the therapists constantly sought to regulate the level of anxiety and aggression in the group. Group-as-a-whole interpretations were not used and the therapists made sure that all group members were active and felt attended to in each session. The dominant focus in group therapy was on how the members experienced and reacted to each other and to predominant themes in the group. Thus the therapists were more active and offered more structure than is recommended in classical group-analytic psychotherapy.

The psychoeducational treatment was conducted in closed groups with 6-8 members and two therapists. Each session opened with a didactic introduction to the main theme of the day by one of the therapists: for instance, what it means to have a borderline disorder, self-destructive behaviour, attachment and relational problems, medical treatment, emotional instability, the core elements of psychoanalytic psychotherapy, etc. Subsequently, the group members discussed their personal experience in relation to the given theme. All the themes introduced related to borderline pathology and the discussions were structured by the therapists.

Individual psychotherapy and psychoeducational group treatment were initiated simultaneously and the psychoeducational groups were used to prepare the patients for group therapy and make the group therapy more acceptable to them. After two months the psychoeducation groups continued as therapy groups – group analytic therapy was thus initiated approximately two months into the individual treatment and all patients were offered a total of two years' treatment. During the period from the time of assessment until a sufficient number of patients had been gathered to start a psychoeducation group, patients were offered individual sessions once a week or every two weeks. The primary intention with these sessions was to engage the patient in treatment, to encourage the establishment of an alliance or an attachment relationship between patient and therapist (and 'the clinic') and to strengthen the patient's motivation for group treatment. The mean duration of this phase was 2.84 months ($SD=2.36$ months).

Participants in the study included: four experienced psychotherapists; two occupational therapists and one nurse, all with three years' formal training in group analytic psychotherapy, substantial training in individual psychotherapy, and approximately twenty years' experience in group analytic treatment, including work with personality disordered patients (primarily cluster C); and one certified clinical psychologist with approximately ten years' experience of working with personality disordered patients.

All individual sessions were videotaped and the therapists were supervised by a highly experienced, psychoanalytically trained supervisor (the second author). The supervision was conducted in two groups, each with two therapists, once a week for two hours. Every fortnight, group therapists received two hours of super-

vision focusing on the group therapy process in a group with all four therapists. On a weekly basis, the therapists presented video-recordings of their therapy sessions to each other and the supervisor as part of the supervision. In addition, all therapists received theoretical training in the treatment model every two weeks (for one and a half hours). This training was structured by an experienced psychoanalytic psychotherapist (the second author). Finally, Anthony Bateman, one of the founders of the mentalization-based treatment model, gave lectures about the model and supervised the therapists on several occasions. Therapy integrity and differentiability and each individual therapist's adherence to the treatment model were thus supported and monitored through close supervision and continuous theoretical training in the psychoanalytic, primarily object-relations and mentalization-based treatment model.

Methods

Treatment outcome and symptom development during therapy were monitored with self-rating questionnaires at three-month intervals. SCL-90-R was used to assess the patients' subjective experience of symptoms. Depression and anxiety symptoms were measured respectively by the Beck Depression Inventory (BDI) and the Beck Anxiety Inventory (BAI). The reliability and validity of these measures is well established. Additionally, the Working Alliance Inventory (WAI) was used to monitor the quality of the patient-therapist relationship. Patients and therapists answered this questionnaire every three months during the whole course of individual therapy. In order to assess areas specifically targeted by psychoanalytic therapy, interpersonal functioning was measured at the beginning of treatment by using the Inventory of Interpersonal Problems (IIP), circumplex version (Horowitz et al. 2000). Finally, we used the defence style questionnaire (DSQ-40) to map the level of maturity in the patient's use of defence mechanisms in daily life.

Statistical Analysis

Not all patients answered the outcome questionnaires issued to them at the appointed time and some patients periodically refused to participate in the self-report regime. In order to calculate mean and standard deviations at selected points in time, we therefore aggregated the outcome data (Admission: -90 through 45 days, 3 months: 46 through 135 days, 6 months: 136 through 230 days etc.). Analyses based only on complete cases can generate biased results. We therefore decided to analyze all available data. Similarly, most analyses were based on all the patients involved, rather than dealing solely with patients who had completed the first fifteen months of treatment. The data analysed from the follow-up period

were based only on those patients who had completed at least fifteen months of treatment, while the aggregation of collected data was based on longer periods of time (24 months: 600-850 days, 32 months: 850-1090 days). All statistical analyses were carried out using SPSS for Windows, version 13.0.

Results

As can be seen in Table 2 and Figures 1 & 2, both self-reported anxiety and self-reported depression decreased during the 15 months of treatment. Similarly, the global severity index (GSI) of the SCL-90 indicated a substantial improvement in general level of functioning. Linear regression analyses showed significant time(number of days)-by-outcome interactions (BAI: $F(1,132)=6.55$, $p=0.01$, BDI: $F(1,130)=4.74$, $p=0.03$, GSI: $F(1,135)=14.36$, $p<0.001$), indicating that all the changes reported are statistically significant. Clinically, the changes in general level of functioning are significant whereas the changes in levels of anxiety and depression must be considered non-significant. On a group level the patients continued to suffer from moderately pathological levels of depression and, to some extent, from general psychiatric symptoms. Viewed individually, five patients moved from moderate or severe depression (measured by BDI) to mild or no depression (BDI-score below 16) during the fifteen months of treatment. Similarly, six patients moved from a GSI-score above to a score below 0.60, which is normally considered the cut-off point for psychiatric pathology.

	BAI-score		BDI-score		SCL-90, GSI-score	
	Mean	SD	Mean	SD	Mean	SD
Admission (N=16)	14.78	11.02	25.00	8.77	1.43	0.55
3 months (N=17)	13.42	6.69	25.02	9.15	1.30	0.38
6 months (N=16)	12.47	8.24	23.39	12.38	1.18	0.58
9 months (N=13)	11.32	8.10	22.35	9.20	1.20	0.48
12 months (N=10)	10.60	8.03	21.35	12.12	1.03	0.43
15 months (N=10)	9.95	9.08	21.25	12.10	0.89	0.49

Table 2. Aggregated Beck Anxiety Index, Beck Depression Inventory and SCL-90, Global Severity Index scores of borderline patients who received psychoanalytically oriented outpatient treatment (N=19)

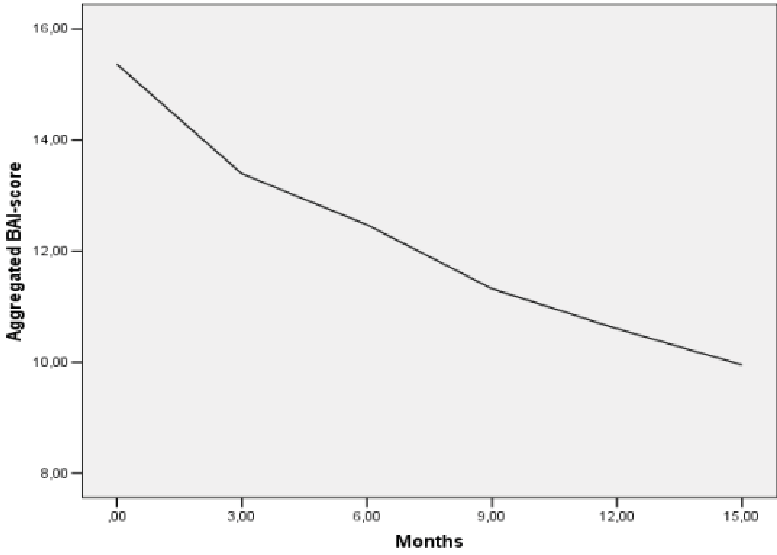


Figure 2: Aggregated BAI-Score, 0-15 months

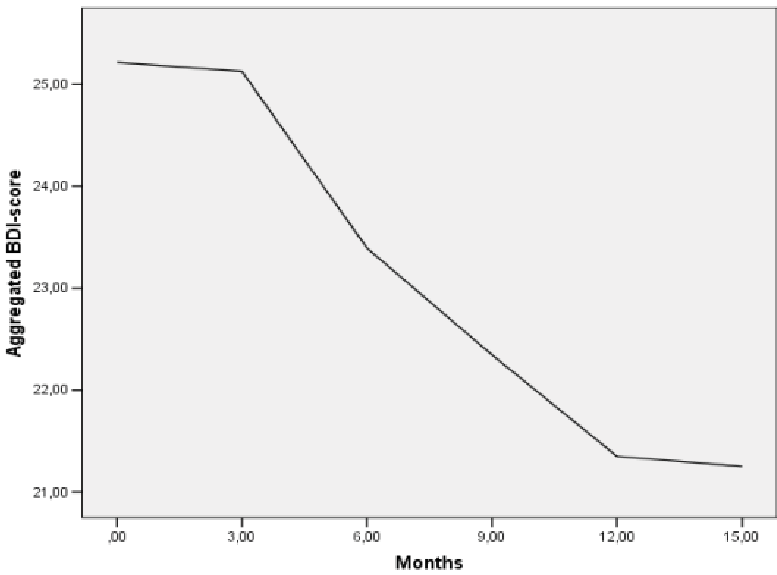


Figure 3: Aggregated BDI-score, 0-15 months

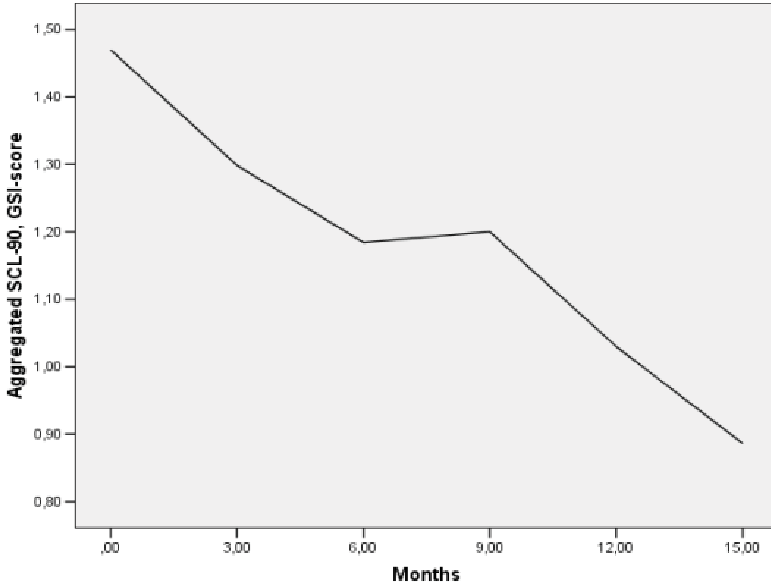


Figure 4: Aggregated SCL-90, GSI-score, 0-15 months

It should be borne in mind that, because of possible selective missing values, the observed differences in mean values over time do not necessarily reflect the true differences. Similarly, one might speculate that a substantial part of the demonstrated outcome is due to the fact that the more severely disturbed patients gradually dropped out of treatment. We therefore did a separate analysis based only on those patients (N=11) who completed the fifteen months of treatment. As can be seen in Table 3, this analysis also demonstrated a substantial treatment outcome and the established changes remained significant (BAI: $F(1,102)=4.15$, $p=0.04$, BDI: $F(1,100)=9.14$, $p=0.003$, GSI: $F(1,104)=15.19$, $p<0.001$). Nevertheless, it cannot be ruled out that individuals who would not benefit from the treatment offered dropped out differentially. Similarly, patients who dropped out prematurely may differ in certain significant (but undetected) ways from patients who continued in treatment.

	BAI-score		BDI-score		SCL-90, GSI-score	
	Mean	SD	Mean	SD	Mean	SD
Admission (N=9)	12.78	10.10	26.56	6.36	1.35	0.48
3 months (N=11)	13.45	6.23	28.62	9.00	1.41	0.41
6 months (N=11)	13.28	9.42	26.54	12.49	1.33	0.56
9 months (N=11)	10.56	8.61	21.86	9.75	1.15	0.51
12 months (N=9)	10.33	8.47	20.50	12.53	1.01	0.45
15 months (N=10)	9.95	9.08	21.25	12.10	0.89	0.49

Table 3. Aggregated Beck Anxiety Index, Beck Depression Inventory and SCL-90, Global Severity Index scores of borderline patients who received at least 15 months of psychoanalytically oriented outpatient treatment (N=11)

Follow-up data indicated not only that the changes reported during treatment by those patients who remained in treatment (N=11) were maintained in the following one and a half years, but that these patients reported an additional decline in levels of anxiety (Mean=9.69, SD=8.35, N=8 at 24 months, and Mean=8.56, SD=9.88, N=8 at 32 months) and depression (Mean=19.50, SD=16.60, N=8 at 24 months and Mean=12.75, SD=12.34, N=8 at 32 months). We also found some additional improvement in the general level of functioning among this group of patients (Mean=0.94, SD=0.77, N=8 at 24 months and Mean=0.77, SD=0.75, N=8 at 32 months).

We found no significant differences in basic demographic and clinical variables between the group of patients who completed and the group who did not complete the fifteen months of treatment. Fisher's exact test showed that neither demographic nor clinical variables on admission (assessment interview), nor general level of patient- or therapist-experienced working alliance differed significantly ($p>0.19$) between the two groups. Differences in levels of mature and neurotic defence mechanisms on admission approached statistical significance ($p=0.07$ and $p=0.10$ respectively, N=15) indicating that mature psychological defences were more compromised on admission in the group of patients who remained in therapy for at least 15 months (mature defence: M= -0.37, SD=1.41

for dropouts; $M = -1.53$, $SD = 0.84$ for completers; neurotic defence: $M = 1.16$, $SD = 0.70$ for dropouts and $M = 0.46$, $SD = 0.80$ for completers). Finally, we did an independent sample T-test on all available clinical variables at the beginning of formal treatment. The only variable that approached statistical significance ($N = 17$, $P = 0.1$) was the GAF symptom-scale, showing that GAF symptom-scores were lower at the beginning of treatment (Mean=44.8, $SD = 5.1$) for the group of patients who completed at least fifteen months of treatment than for the group of patients who terminated the treatment prematurely (Mean=51.6, $SD = 10.3$). Again the standard deviations were high, indicating that the two groups of patients were highly heterogeneous. Nevertheless, the observed improvements might, at least partly, reflect regression toward the mean. Finally, one could speculate that the withdrawal of (in part excessive) medication could be a confounding variable. Seven of the eleven patients who completed at least 15 months of treatment had their medication significantly reduced or withdrawn. This was only the case for one of the eight patients who ended the treatment within the first 15 months. A Fisher's exact test showed that this difference approached statistical significance ($P < 0.06$).

Discussion

The study suggests that intensive outpatient treatment based on psychoanalytic principles benefits patients with borderline personality disorder. After 15 months of treatment we found significant changes in self-reported levels of anxiety, depression and general functioning. Thus the study contributes to the increasingly positive treatment outlook for patients with borderline personality disorder.

Compared with those in other studies of treatment outcome (especially Bateman & Fonagy 1999), patients in this study were less severely disturbed and the demonstrated outcomes were only moderately significant. The relatively high general level of functioning in our patients, compared with those in some other studies, is partly due to the fact that the study was conducted in an outpatient setting, rather than an inpatient setting or a day hospital.

Similarly, the relatively high attrition rate could partly be explained by the fact that the treatment was conducted in a relatively unstructured outpatient clinic and that the clinic was still under construction when the study was initiated. Dropout rates from treatment among borderline patients vary considerably across studies (Perry et al. 1999, Leichsenring & Leibling 2003) and depend on how dropout is defined. We still lack a common and widely accepted definition of treatment dropout. Typically, the percentage of dropouts is significantly lower for treatments of shorter duration (Perry et al. 1999). In addition, dropout is normally higher for group therapy than for individual psychotherapy. At least two of the dropouts in

this study were directly related to the patient's rejection of group treatment. Three further dropouts resulted from the fact that one of the therapists went on maternity leave, and were therefore not directly related to the treatment model offered. All referred borderline patients who intended to receive treatment were included in the study. This also contributed to the relatively high dropout rate. Other studies involving intention-to-treat analyses on long-term treatment in outpatient settings (Giesen-Bloo et al.2006) have reported comparable attrition rates. In general, it must be acknowledged that the borderline patient's characteristic instability, fluctuating compliance and propensity for impulsive acting-out of aggressive impulses makes it extremely difficult to conduct perfectly controlled studies with this group of patients.

In an investigation of the empirical evidence for the effectiveness of psychotherapeutic treatment of personality disorder Bateman & Fonagy (2000) conclude that "there is relatively little compelling evidence that individuals with personality disorders and low levels of functioning can be successfully treated on an out-patient basis". Thus, one may speculate that the outcome in this study would have been more significant and the attrition rate lower if the patients had been offered more intensive treatment in a more structured (day-hospital) setting. Nevertheless, the study demonstrated significant outcome from the psychoanalytically based out-patient treatment offered.

Limitations of the study

The size of the group studied was small and we experienced additional loss of power from the attrition of subjects, from the fact that some patients periodically refused to cooperate in answering the required self-report questionnaires, and from the fact that data had to be aggregated due to instability in the patients' answering of outcome questionnaires. Our follow-up data were compromised by additional attrition and we were able to follow only eight (42%) of the nineteen patients admitted for the full period of thirty-two months. The experienced problems with low statistical power and a high drop-out rate are not unique for this study. These are relatively common problems in studies of borderline treatment. The classical studies presented by Linehan and colleagues (1991, 1994) are based on less than fifty patients and the drop-out rates are 20-30%. Similarly, the groundbreaking study by Bateman and colleagues (1999, 2001) is based on only 38 patients, with a reported drop-out rate of 12%. In addition to this, some studies use insufficiently defined and significantly different definitions of drop-out.

Despite the relatively few subjects involved, reported changes in this study were statistically and to some extent clinically significant. The reported change in mean level of anxiety – from approximately 15 on admission to 10 after fifteen

months – is statistically significant but remains within what is normally considered a mild level of anxiety. In that sense, the changes are clinically insignificant.

Diagnoses of borderline personality disorder were based on unstructured clinical interviews and the validity of the diagnoses could have been supported substantially by the use of a standard interview format (e.g. SCID-II). In addition, there were insufficient data on the co-morbidity of other personality disorders and (axis I) symptom diagnoses. Finally, only self-report measures were used to test treatment outcome and these reports could have been substantiated by using observer-rated measures such as Global Assessment of Functioning (GAF) as well.

The levels of functioning reported at different points of treatment were characterized by high standard deviations, indicating that the patient sample studied was relatively heterogeneous; by a substantial variation in level of function both before and after the treatment offered, and by a relatively high level of variation in outcome.

Although we tried to ensure treatment integrity through close supervision and ongoing therapist-training, no formalized procedures were used to monitor adherence to the treatment model. Thus it was not possible to locate the specific therapeutic factors or the active ingredients at work in the treatment offered (Jørgensen 2004). This problem applies to a more or less marked degree to all outcome studies and is only partially solved by using formalized treatment manuals, adherence scales etc. In addition, some patients were offered individual sessions before the treatment was formally initiated (until a sufficient number of patients had been gathered for the psychoeducation groups). Consequently, it is difficult to be precise about treatment duration and it is possible that certain patients may have changed as a consequence of these ‘alliance-building’ sessions.

The study did not include a control group condition in which some of the patients were randomly assigned to an alternative treatment. This procedure has been included in an ongoing study where we are currently collecting data from approximately one hundred borderline patients. The absence of a comparison group limits our interpretation of the positive effects demonstrated. Thus we were not able to adjust for change due solely to attention, to time or to regression toward the mean, and we may have overestimated the level of change due to specific therapeutic interventions. However, the symptoms and emotional difficulties of patients with a borderline personality disorder are usually relatively stable over longer periods of time (years). The literature (e.g. Paris 2003, Perry et al. 1999) tends to support the view that borderline patients are unlikely to show substantial improvement within fifteen months and if they do so the improvement is probably due to treatment. It is therefore reasonable to assume that the positive changes observed can be attributed to the treatment offered.

REFERENCES

- Bateman, A. & Fonagy, P. (1999). Effectiveness of Partial Hospitalization in the Treatment of Borderline Personality Disorder: A Randomized Controlled Trial. *American Journal of Psychiatry*, 156, 1563-69
- Bateman, A. & Fonagy, P. (2000). Effectiveness of Psychotherapeutic Treatment of Personality Disorder. *British Journal of Psychiatry*, 138-43
- Bateman, A. & Fonagy, P. (2001). Treatment of Borderline Personality Disorder with Psychoanalytically Oriented Partial Hospitalization: An 18-Month Follow-Up. *American Journal of Psychiatry*, 158, 36-42
- Bateman, A. & Fonagy, P. (2003a). The Development of an Attachment-Based Treatment Program for Borderline Personality Disorder. *Bulletin of the Menninger Clinic*, 67, 187-211
- Bateman, A. & Fonagy, P. (2003b). Health Service Utilization Costs for Borderline Personality Disorder Patients Treated with Psychoanalytically Oriented Partial Hospitalization Versus General Psychiatric Care. *American Journal of Psychiatry*, 160, 169-71
- Bateman, A. & Fonagy, P. (2004). *Psychotherapy for Borderline Personality Disorder. Mentalization-Based Treatment*. Oxford: Oxford University Press
- Bohus, M., Haaf, B., Simms, T., Limberger, M.F., Schmahl, C., Unckel, C., Lieb, K. & Linehan, M. (2004). Effectiveness of Inpatient Dialectical Behavioral Therapy for Borderline Personality Disorder: A Controlled Trial. *Behavior Research and Therapy*, 42, 487-99
- Clarkin, J.F., Yeomans, F.E. & Kernberg, O.F. (1999). *Psychotherapy for Borderline Personality*. New York: Wiley
- Clarkin, J.F., Foelsch, P.A., Levy, K.N., Hull, J.W., Delaney, J.C. & Kernberg, O.F. (2001). The Development of a Psychodynamic Treatment for Patients with Borderline Personality Disorder: A Preliminary Study of Behavioral Change. *Journal of Personality Disorders*, 15, 487-95
- Clarkin, J.F., Yeomans, F.E. & Kernberg, O.F. (2006). *Psychotherapy for Borderline Personality. Focusing on Object Relations*. Washington: American Psychiatric Publishing
- Cookson, A., Espie, J. & Yates, K. (2001). The Edinburgh Project: A Pilot Study for the Psychotherapeutic Treatment of Borderline and other Severe Personality Disorders. *British Journal of Psychotherapy*, 18, 68-88
- Den Bosch, L.M.C., Koeter, M.W.J., Stijnen, T., Verheul, R. & Den Brink, W. (2005). Sustained Efficacy of Dialectical Behaviour Therapy for Borderline Personality Disorder. *Behaviour Research and Therapy*, 43, 1231-41
- Gabbard, G.O., Laza, S.G., Hornberger, J. & Spiegel, D. (1997). The Economic Impact of Psychotherapy: A Review. *American Journal of Psychiatry*, 154, 147-55
- Gabbard, G.O. (2000). *Psychodynamic Psychiatry in Clinical Practice*. Washington: American Psychiatric Press
- Giesen-Bloo, J., Dyck, R., Spinhoven, P., Tilburg, W., Dirksen, C., Asselt, T., Kremers, I., Nadort, M. & Arntz, A. (2006). Outpatient Psychotherapy for Borderline Personality Disorder. Randomized Trial of Schema-Focused Therapy vs. Transference-Focused Psychotherapy. *Archives of General Psychiatry*, 63, 649-58
- Gunderson, J.G., Berkowitz, C. & Ruiz-Sancho, A. (1997). Families of Borderline Patients: A Psychoeducational Approach. *Bulletin of the Menninger Clinic*, 61, 446-57
- Gunderson, J.G. (2001). *Borderline-Personality Disorders. A Clinical Guide*. Washington: American Psychiatric Press
- Guntrip, H. (1961). *Personality Structure and Human Interaction. The Developing Synthesis of Psychodynamic Theory*. London: Karnac Books
- Horowitz, L.M., Alden, L.E., Wiggins, J.S. & Oincus, A.L. (2000). *Inventory of Interpersonal Problems. Manual*. San Antonio: The Psychological Corporation
- Jørgensen, C.R. (2004). Active Ingredients in Individual Psychotherapy. Searching for the Common Factors. *Psychoanalytic Psychology*, 21, 516-41
- Jørgensen, C.R. (2006a). Personlighedsforstyrrelser. Moderne Relationel Forståelse og Behandling af Borderline lidelser [Personality Disorders. Modern Relational Understanding and Treatment of Borderline Disorders]. Copenhagen: Akademisk Forlag
- Jørgensen, C.R. (2006b). Disturbed sense of identity in borderline personality disorder. *Journal of Personality Disorder*, 20, 618-45

- Kernberg, O.F., Selzer, M.A., Koenigsberg, H.W., Carr, A.C. & Appelbaum, A.H. (1989). *Psychodynamic Psychotherapy of Borderline Patients*. New York: Basic Books
- Leichsenring, F. & Leibing, E. (2003). The Effectiveness of Psychodynamic Therapy and Cognitive Behavior Therapy in the Treatment of Personality Disorders: A Meta-Analysis. *American Journal of Psychiatry*, 160, 1223-32
- Linehan, M.M., Armstrong, H.E., Suarez, A., Allmon, D. & Heard, H.L. (1991). Cognitive Behavioral Treatment of Chronically Parasuicidal Borderline Patients. *Archives of General Psychiatry*, 48, 1060-64
- Linehan, M.M., Heard, H.L. & Armstrong, H.E. (1993). Naturalistic Follow-Up of a Behavioral Treatment for Chronically Parasuicidal Borderline Patients. *Archives of General Psychiatry*, 50, 971-74
- Linehan, M.M., Tutek, D.A., Heard, H.L. & Armstrong, H.E. (1994). Interpersonal Outcome of Cognitive Behavioral Treatment for Chronically Suicidal Borderline Patients. *American Journal of Psychiatry*, 151, 1771-76
- Mattia, J.I. & Zimmerman, M. (2001). Epidemiology. In: Livesley, W.J. (ed.). *Handbook of Personality Disorders*, 107-23. New York: Guilford
- Mearns, R., Stevenson, J. & Comerford, A. (1999). Psychotherapy with Borderline Patients: A Comparison between Treated and Untreated Cohorts. *Australian and New Zealand Journal of Psychiatry*, 33, 467-72
- Marziali, E. & Monroe-Blum, H. (1994). *Interpersonal Group Psychotherapy for Borderline Personality Disorder*. New York: Basic Books
- Munroe-Blum, H. & Marziali, E. (1995). A Controlled Trial of Short-Term Group Treatment for Borderline Personality Disorder. *Journal of Personality Disorders*, 9, 190-98
- Oldman, J.M., Philips, K.A., Gabbard, G.O., Goin, M.K., Gunderson, J., Soloff, P, Spiegel, D. & Stone, M. (2001). Practice Guideline for the Treatment of Patients with Borderline-personality Disorder. *American Journal of Psychiatry*, 158, supplement
- Paris, J. (2003). *Personality Disorders over Time. Precursors, Course, and Outcome*. Washington: American Psychiatric Publishing
- Perry, J.C. & Banon, E. & Ianni, F. (1999). Effectiveness of Psychotherapy for Personality Disorders. *American Journal of Psychiatry*, 156, 1312-21
- Stevenson, J. & Mearns, R. (1992). An Outcome Study of Psychotherapy for Patients with Borderline Personality Disorder. *American Journal of Psychiatry*, 149, 358-62
- Stevenson, J. & Mearns, R. (2003). Psychotherapy with Borderline Patients; A Preliminary Cost Benefit Study. *Australian and New Zealand Journal of Psychiatry*, 33, 473-77
- Stevenson, J. & Mearns, R., D'Angelo, R. (2005). Five-Year Outcome of Outpatient Psychotherapy with Borderline Patients. *Psychological Medicine*, 35, 79-87
- Verheul, R., Den Bosch, L.M.C., Koeter, M.W.J., De Ridder, M.A.J., Stijnen, T. & Den Brink, W. (2003). Dialectical Behavior Therapy for Women with Borderline Personality Disorder. 12-Month, Randomised Clinical Trial in The Netherlands. *British Journal of Psychiatry*, 182, 135-40
- Winnicott, D. (1971). *Playing and Reality*. London: Karnac Books