UNIVERSITY OF AMSTERDAM

Borderline Persoonlijkheidsstoornis

Arnoud Arntz

30 jaar geleden

- Onbehandelbaar
- Stigma
- “Gehele” persoon
  - “je bent Borderline” vs. “je hebt een Borderline PS”

Achtergrond

- Borderline: op de grens tussen neurose en psychose
  - Slechte reactie op klassieke psychoanalyse (psychotische symptomen getriggered)
- Voorkomen = 1-2 % (≈ schizofrenie & bipolair samen!)
- Zeer ernstig:
  - Lage Kwaliteit van Leven
  - Hoge maatschappelijke kosten:
    - school niet afgerond
    - productiviteitsverliezen
    - arbeidsongeschikt / werkeloosheid
    - gezondheidszorgkosten / vroegtijdige dood
    - intergenerationele overdracht etc.
  - Hoog suïcide % (≈ 10%)
  - Drugs/alcohol problematiek, forensische problemen

BPS: diagnostische criteria (DSM-5) (BPD ≥ 5)

1. Extreme verlatingsangst & verlating verhinderen
2. Intense & instabiele relaties
3. Identiteitsstoornis
4. Zelfbeschadigende impulsiviteit
5. Suïcidaal & zelfverwondingsgedrag
6. Affectieve instabiliteit
7. Chronische leegte
8. Ongepaste woede
9. Stress-gerelateerde paranoïde overtuigingen of ernstige dissociatie

Ontstaan

- In puberteit
- Geen eenduidige oorzaak
- Erfelijkheid
  - ± 50% (tweelingstudies)
  - Geen gen gevonden
  - Gecontroleerd voor erfelijkheid van “gewone” persoonlijkheidstrekken (bv. *Neuroticisme)* geen erfelijkheid van BPS (Distel et al., 2009)
  - Kwetsbaarheid x omgeving → BPS
- Omgeving
  - Verwaarlozing & misbruik id kindertijd

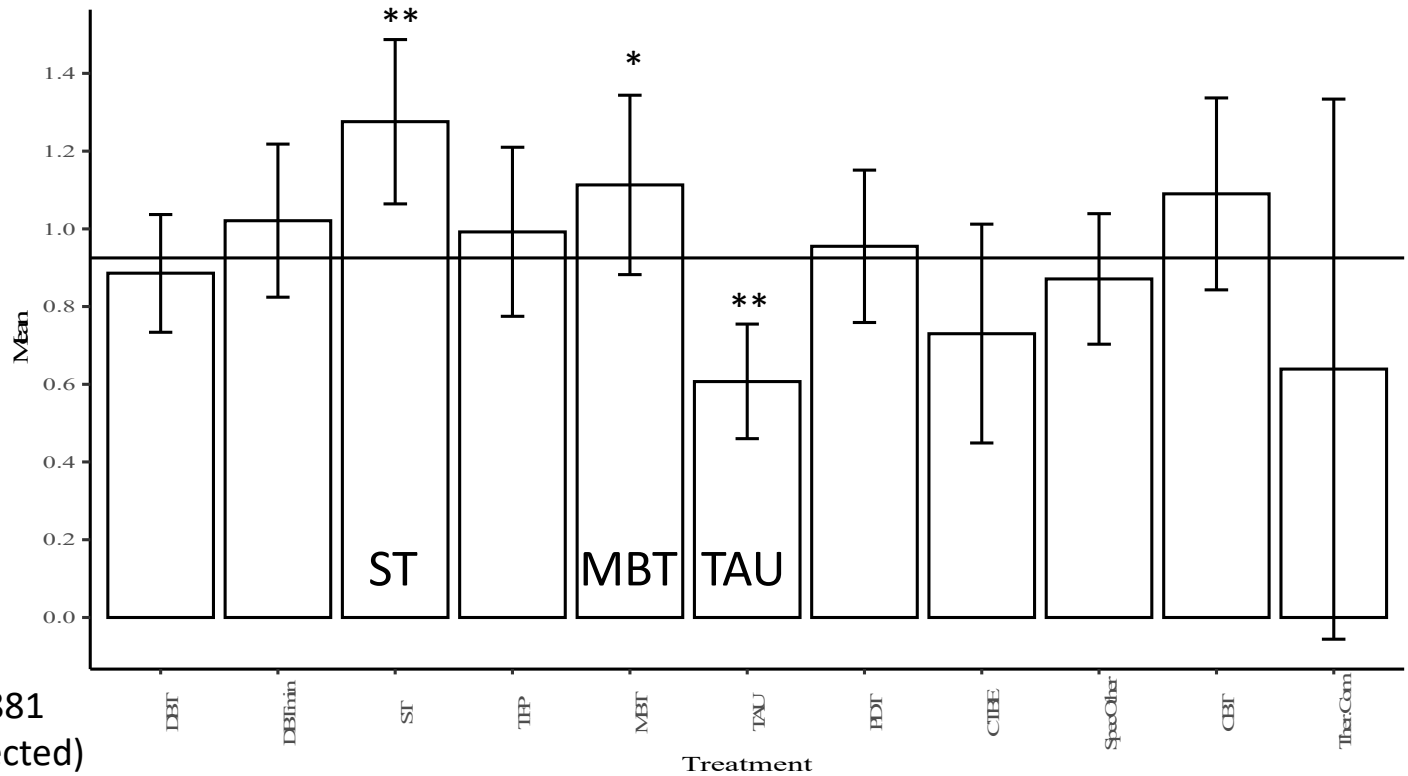
Behandeling

- Geen farmacotherapie voor BPS
  - Wel voorgeschreven voor specifieke domeinen (bv., emotionele symptomen: stemmingsstabilisator of antipsychoticum)
  - Onderdrukking of behandeling?
- Voorkeursbehandeling: specialistische psychotherapie
- Echter, 75% van BPS patients in NL ontvangt geen psychotherapie

  (Trimbos instituut studie naar implementatie van richtlijn)

Meta-analysis of pre-post effect sizes BPD-severity at 1 year.

Rameckers et al. J. Clin. Med. 2021, 10, 5622. https://doi.org/10.3390/jcm10235622

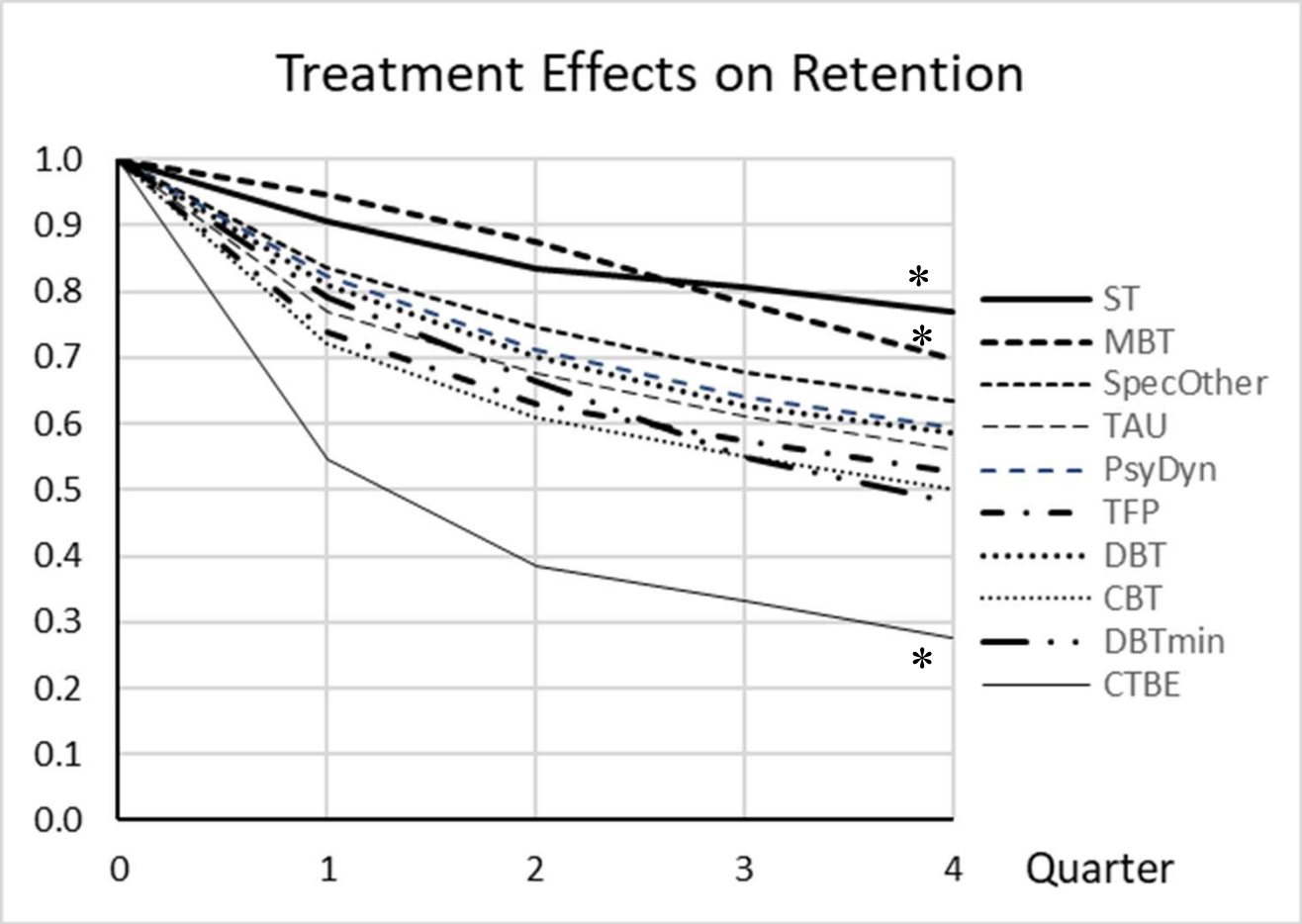


87 studies, N=5881
* p<.05 (uncorrected)
** p<.001 (corrected)

Dropout van behandeling: effect van soort therapie

Arntz et al. (2022) Psychological Medicine, accepted for publication

111 studies
159 treatment arms
N=9100



Dropout van behandeling: effect behandel-format

Arntz et al. (2022) Psychological Medicine, accepted for publication

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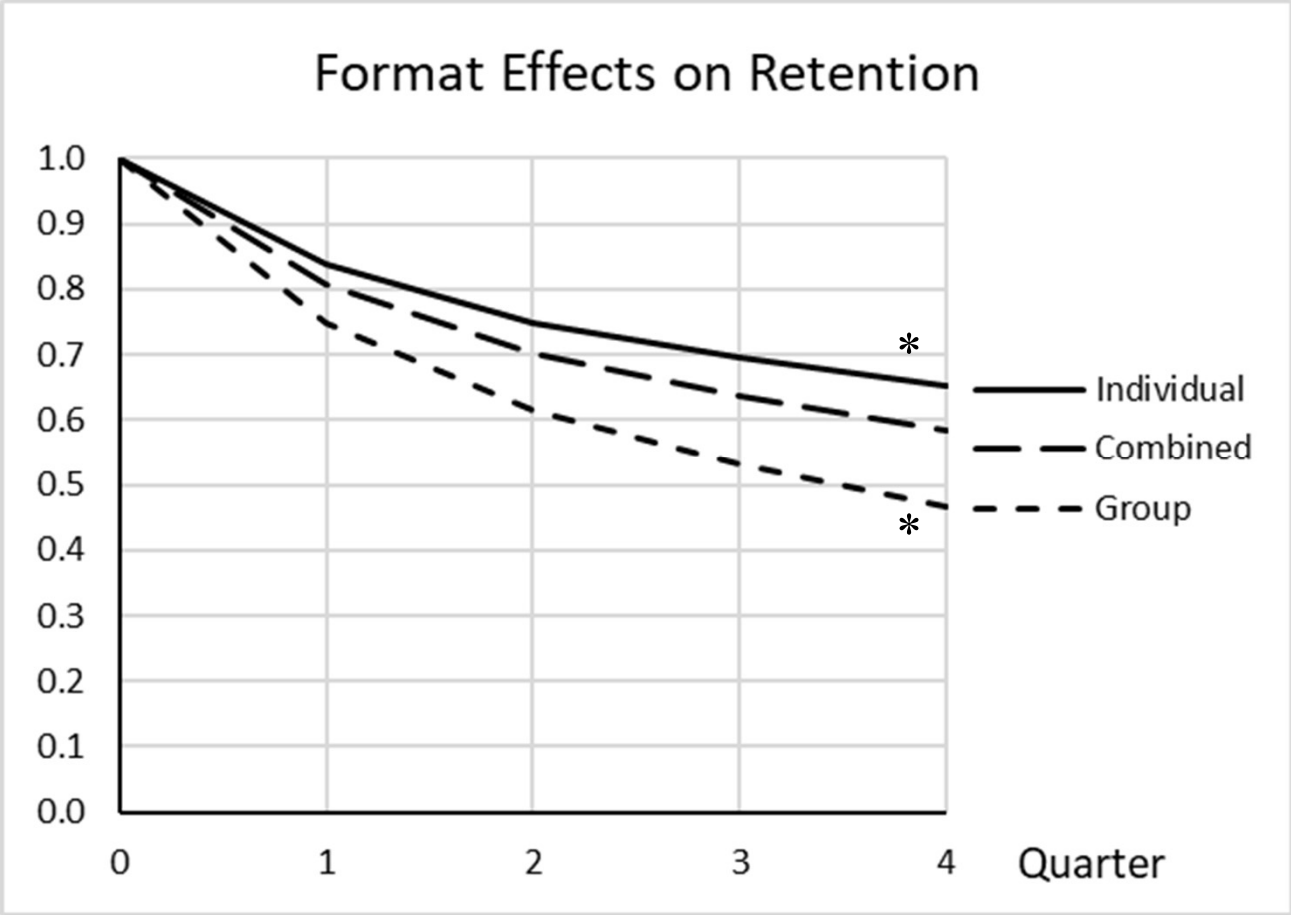
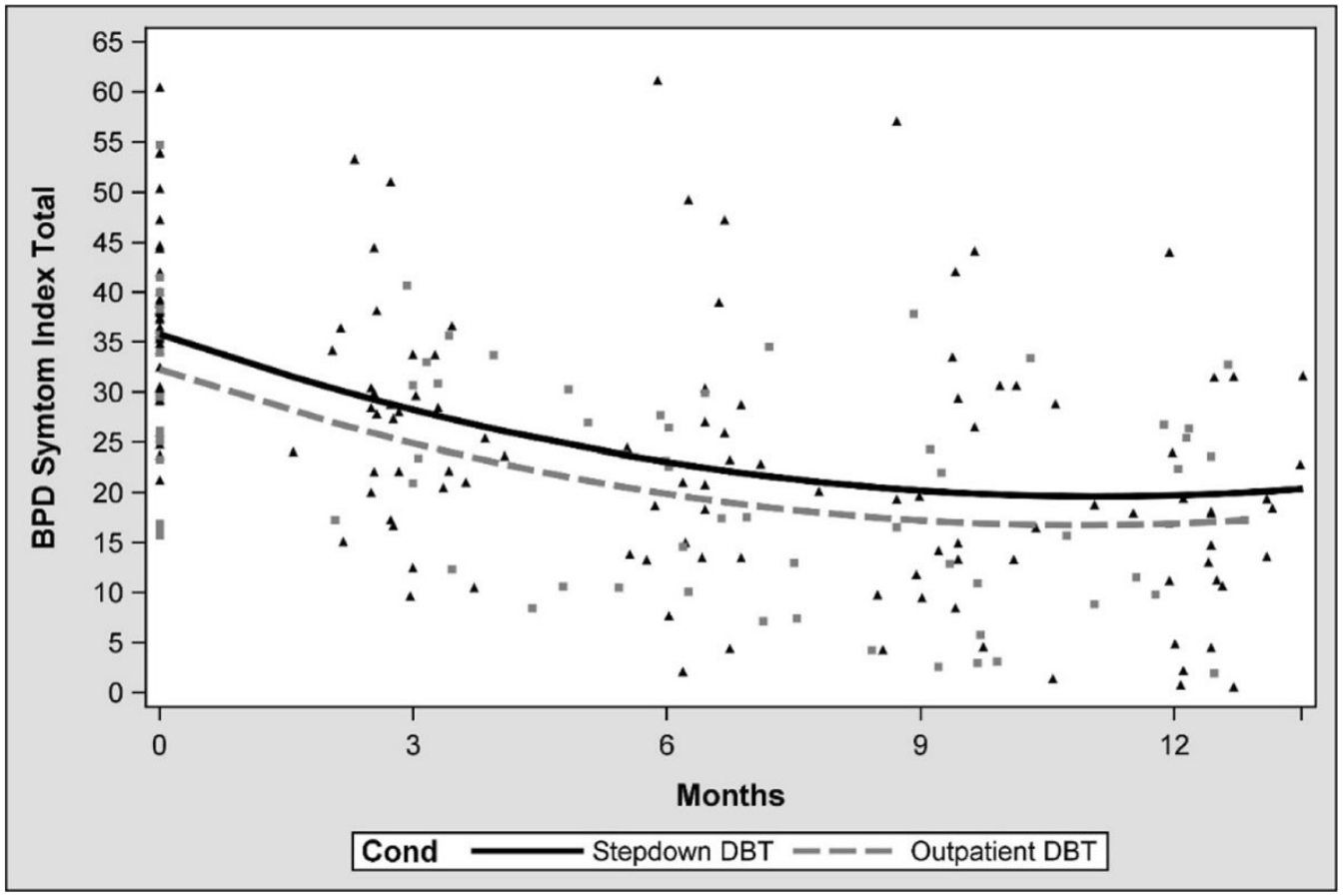


Nog meer bevindingen

- Ambulante therapie niet slechter dan dag- of klinische therapie
- Langere therapie = betere effecten

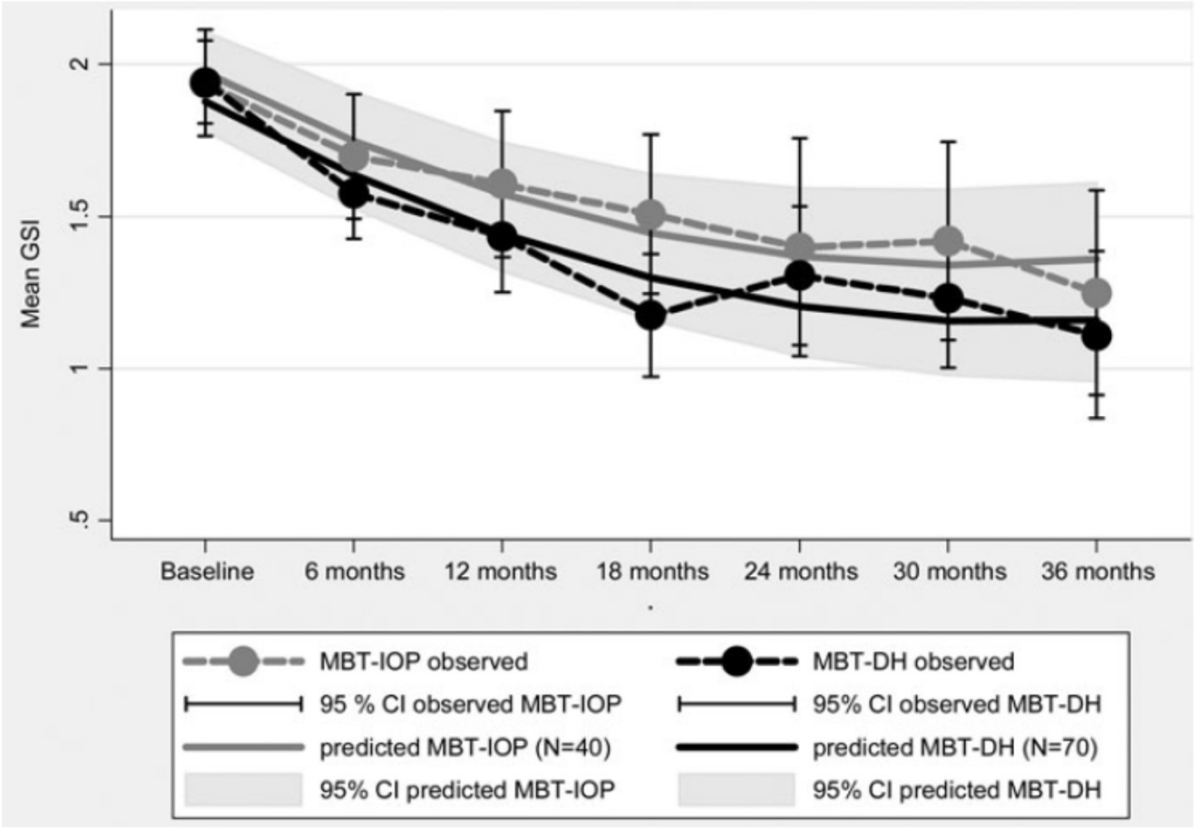
Inpatient vs. outpatient DBT for BPD: BPD severity

Sinnaeve et al (2018). Borderline Personality Disorder and Emotion Dysregulation, 5:12



Day vs. intensive outpatient treatment: MBT

Smits et al (2020). Psychological Medicine 1–11. https://doi.org/10.1017/S0033291720002123



N.S. difference

Schematherapie

- Fundamentele emotionele behoeften
- Emotionele behoeften gefrustreerd: dysfunctionele schema's
- Therapie:
  - Aanbieden van correctieve ervaringen (wél voorzien in behoeften)
    - Ook in de therapeutische relatie
    - Veiligheid ervaren in voelen van emoties
  - Verwerking van traumatische ervaringen uit de kindertijd
    - Uniek voor schematherapie
  - Veel gebruik van "experientiële" technieken
    - Doorbreken van vermijden van emoties

JAMA Psychiatry | Original Investigation

Effectiveness of Predominantly Group Schema Therapy and Combined Individual and Group Schema Therapy for Borderline Personality Disorder
A Randomized Clinical Trial

Arnoud Arntz, PhD; Gitta A. Jacob, PhD; Christopher W. Lee, PhD; Odette Manon Brand-de Wilde, PhD; Eva Fassbinder, MD; R. Patrick Harper, MSc; Anna Lavender, DClinPsy; George Lockwood, PhD; Ioannis A. Malogiannis, DrMed; Florian A. Ruths, DrMed; Ulrich Schweiger, DrMed; Ida A. Shaw, MA; Gerhard Zarbock, PhD; Joan M. Farrell, PhD

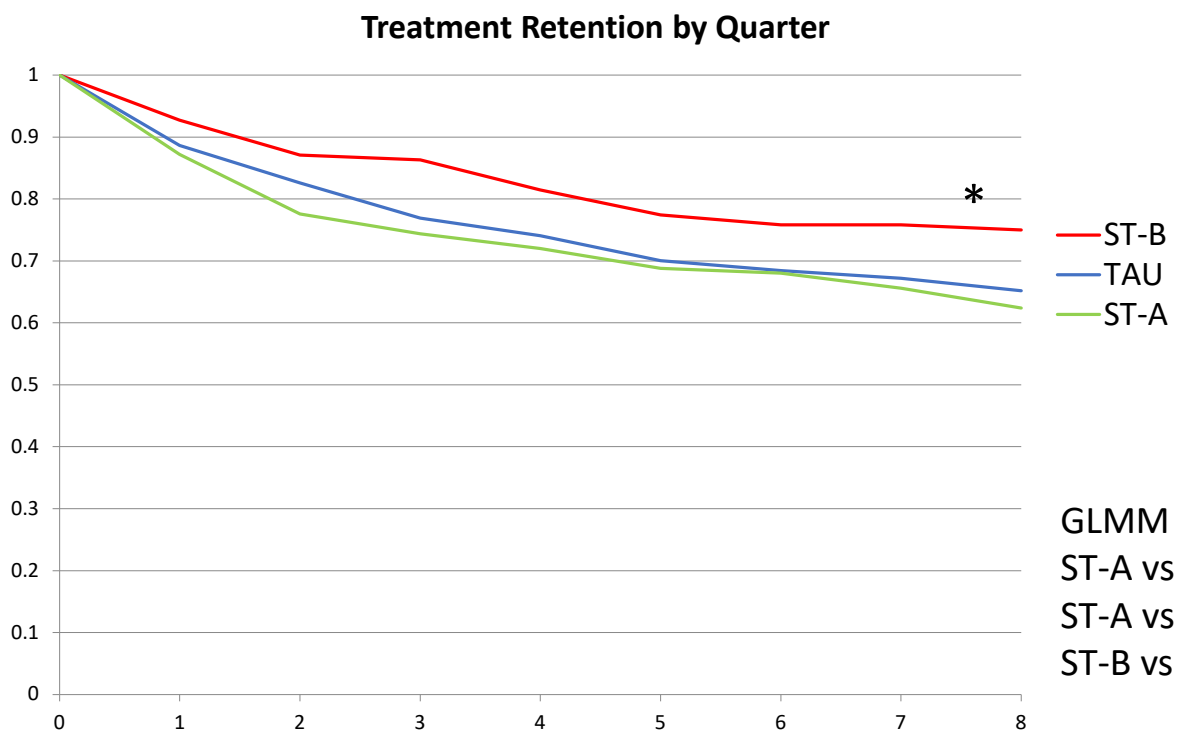
IMPORTANCE Schema therapy (ST), delivered either in an individual or group format, has been compared with other active treatments for borderline personality disorder (BPD). To our knowledge, the 2 formats have not been compared with treatment as usual (TAU) or with each other. Such comparisons help determine best treatment practices.

OBJECTIVE To evaluate whether ST is more effectively delivered in a predominantly group or combined individual and group format and whether ST is more effective than optimal TAU for BPD.

Visual Abstract

Supplemental content

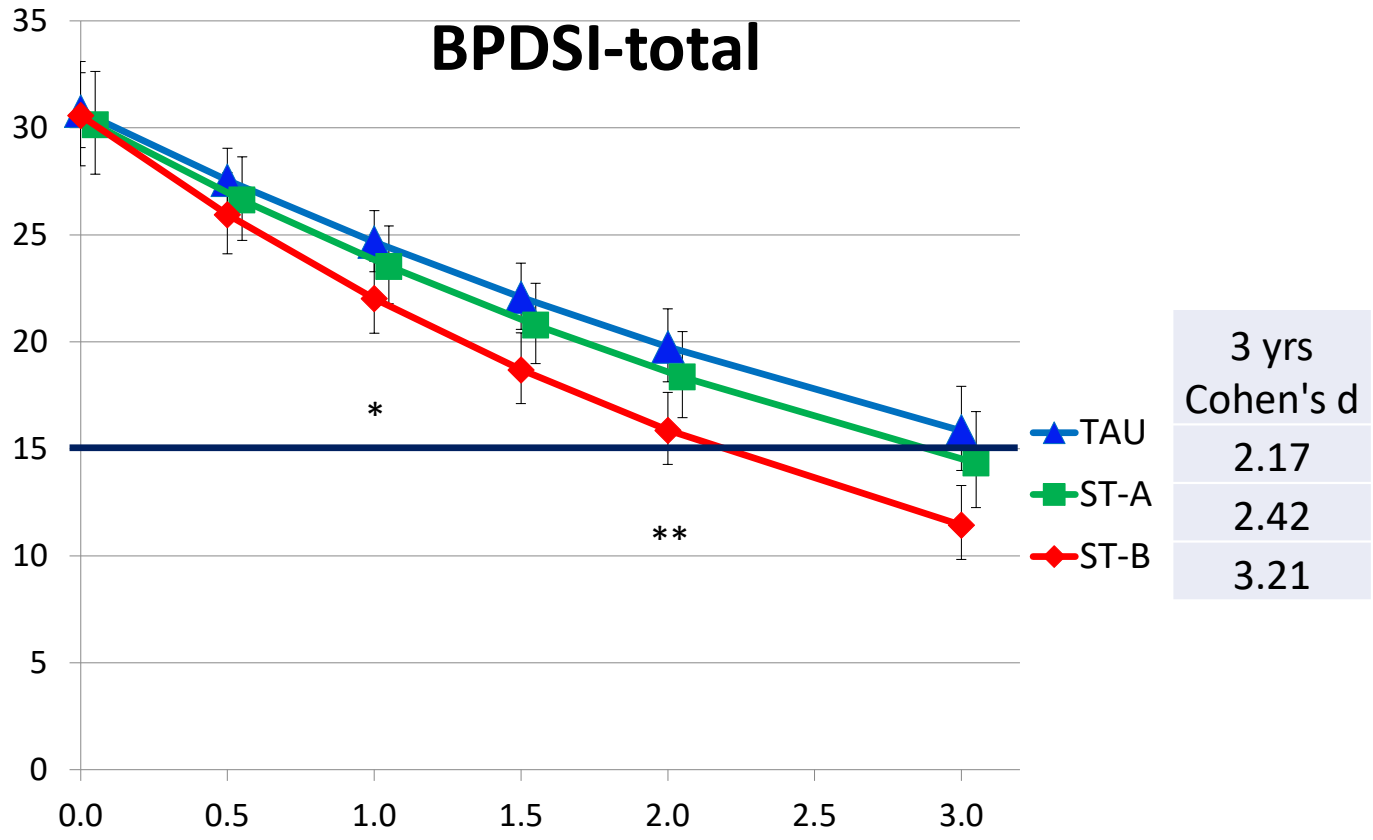
Treatment Retention:
ST-B superior to S-TAU and ST-A



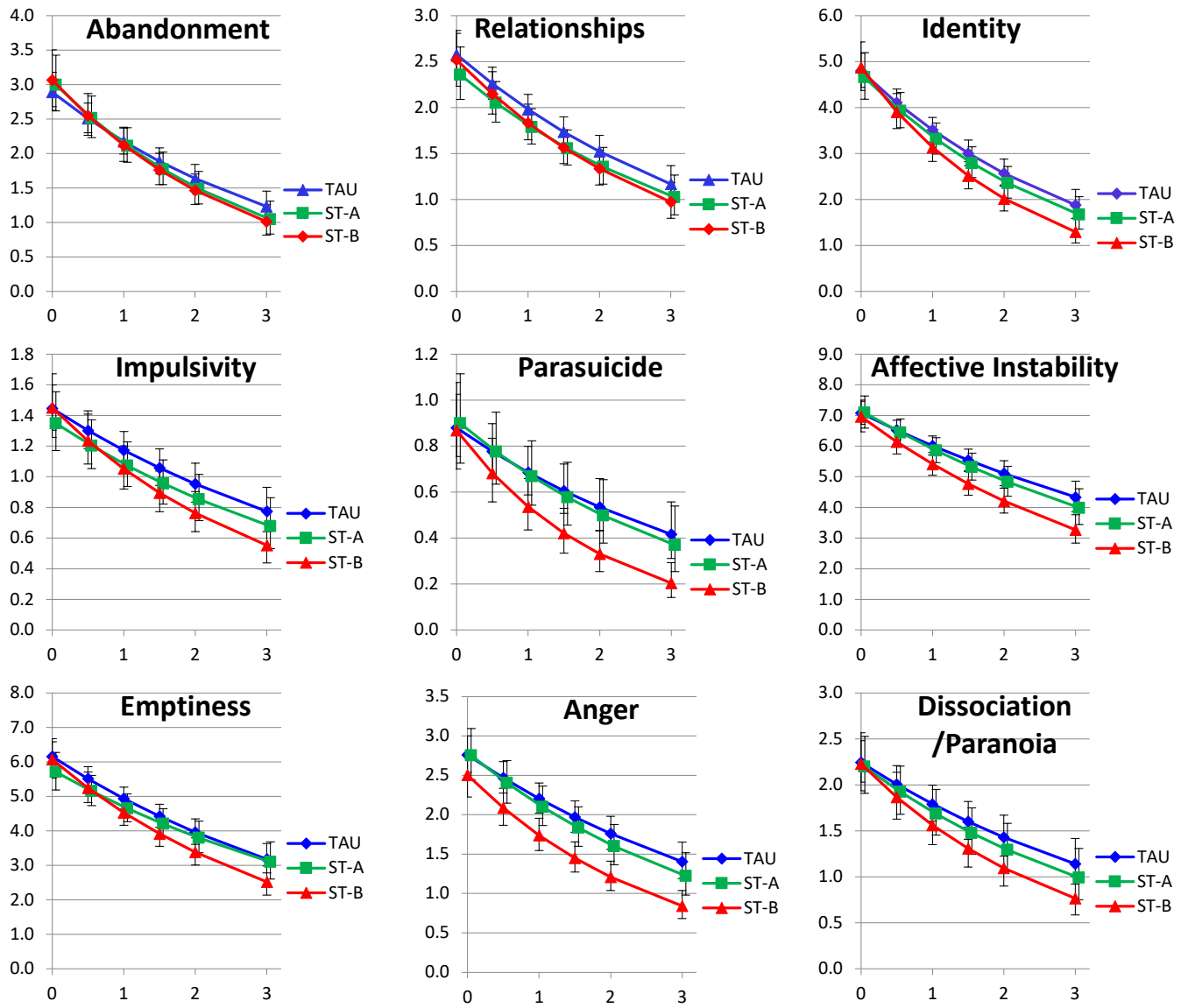
GLMM survival analysis:
ST-A vs TAU p = .74
ST-A vs ST-B p = .041*
ST-B vs TAU p = .043*

Primary Outcome BPD-severity over 3 years

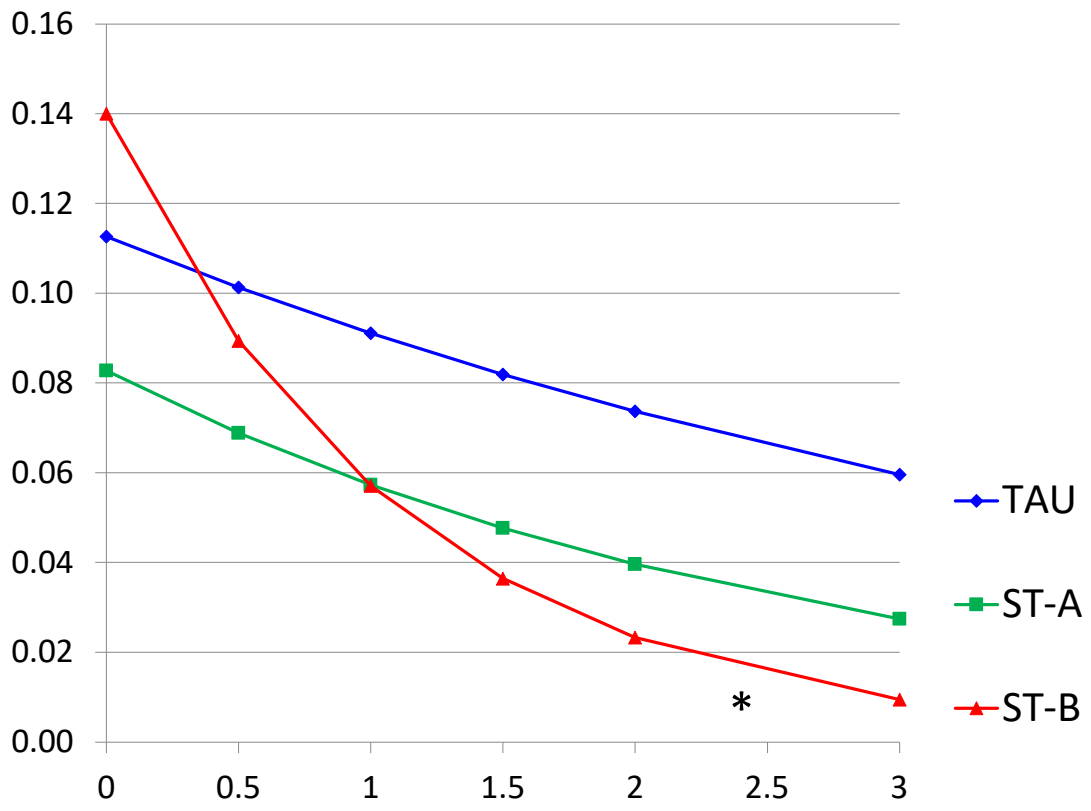
independent blinded raters (estimated means (95% CIs))



*At 1 year ST-B became significantly superior to TAU, **at 2 years significantly superior to ST-A. ST-A did not differ significantly from TAU.

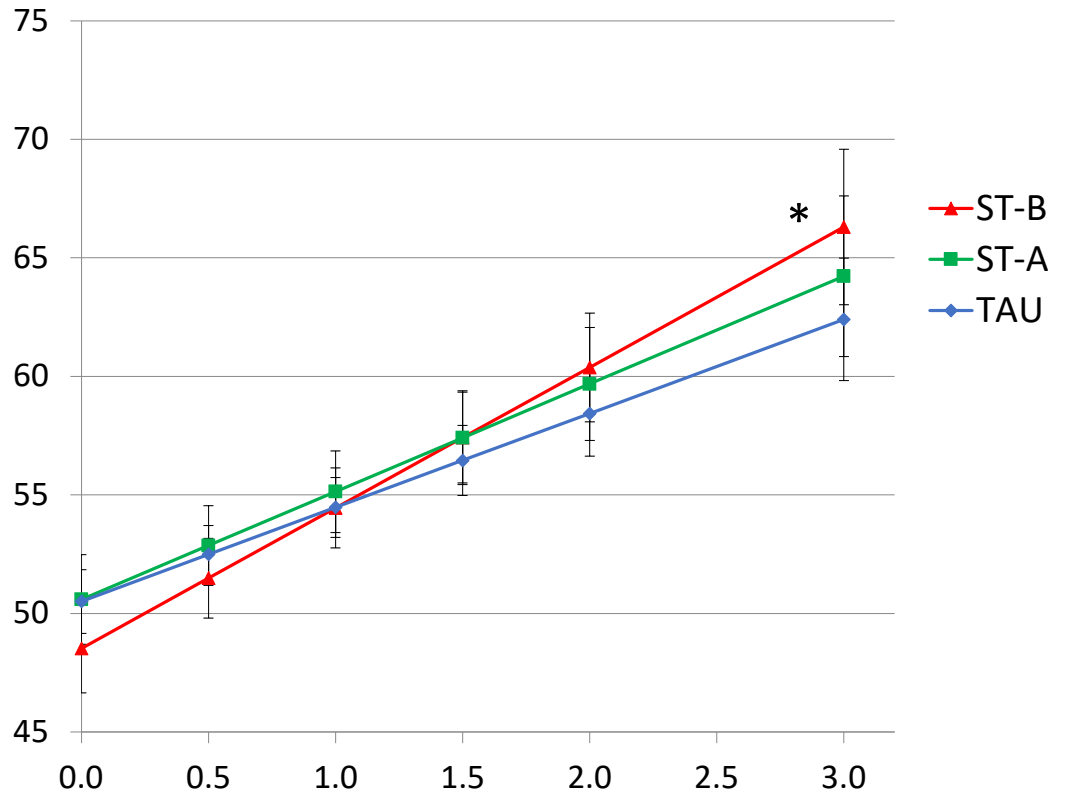

Abandonment
Relationships
Identity
Impulsivity
Parasuicide
Affective Instability
Emptiness
Anger
Dissociation /Paranoia
TAU
ST-A
ST-B

Suicide Attempts
(numbers per quarter)



	Cohen's d
TAU	0.12
ST-A	0.21
ST-B	0.51

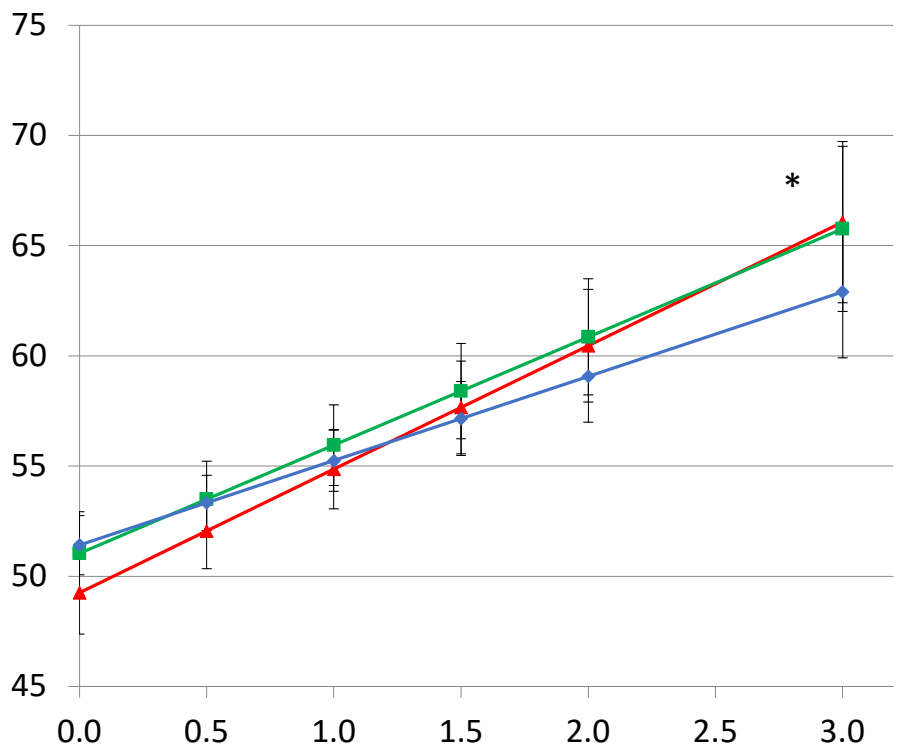
GAF
(independent blinded raters)



	Cohen's d
ST-B	**2.10**
ST-A	**1.61**
TAU	**1.41**

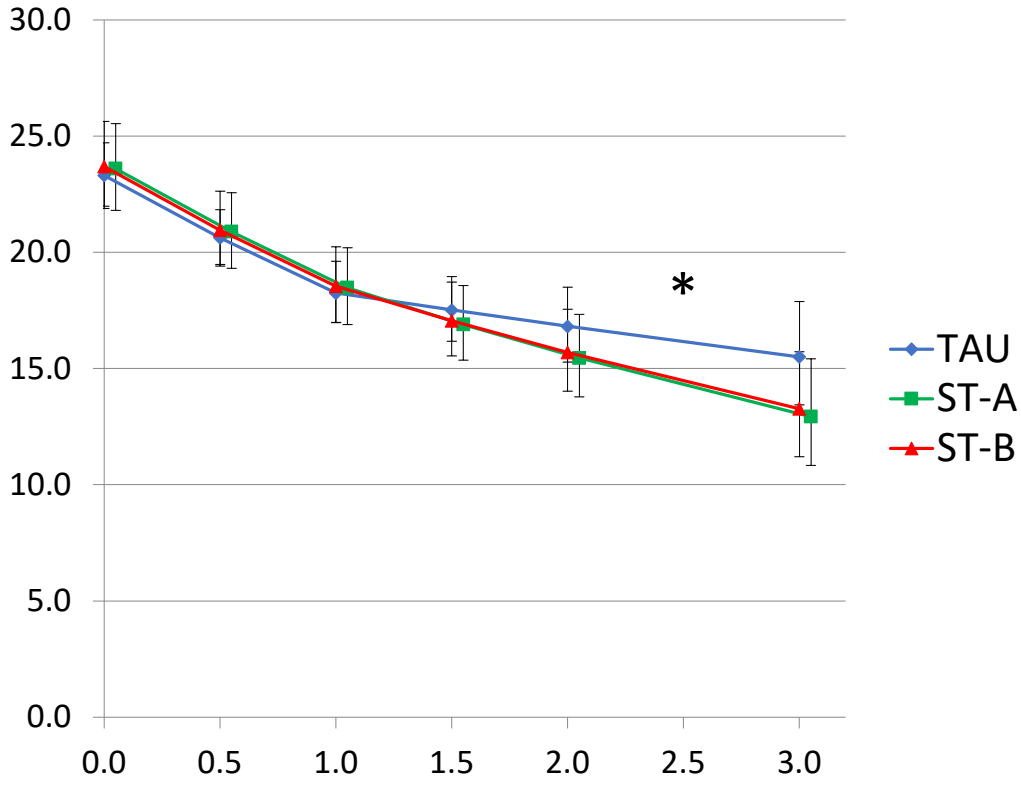
SOFAS

(social functioning assessed by independent blinded rater)



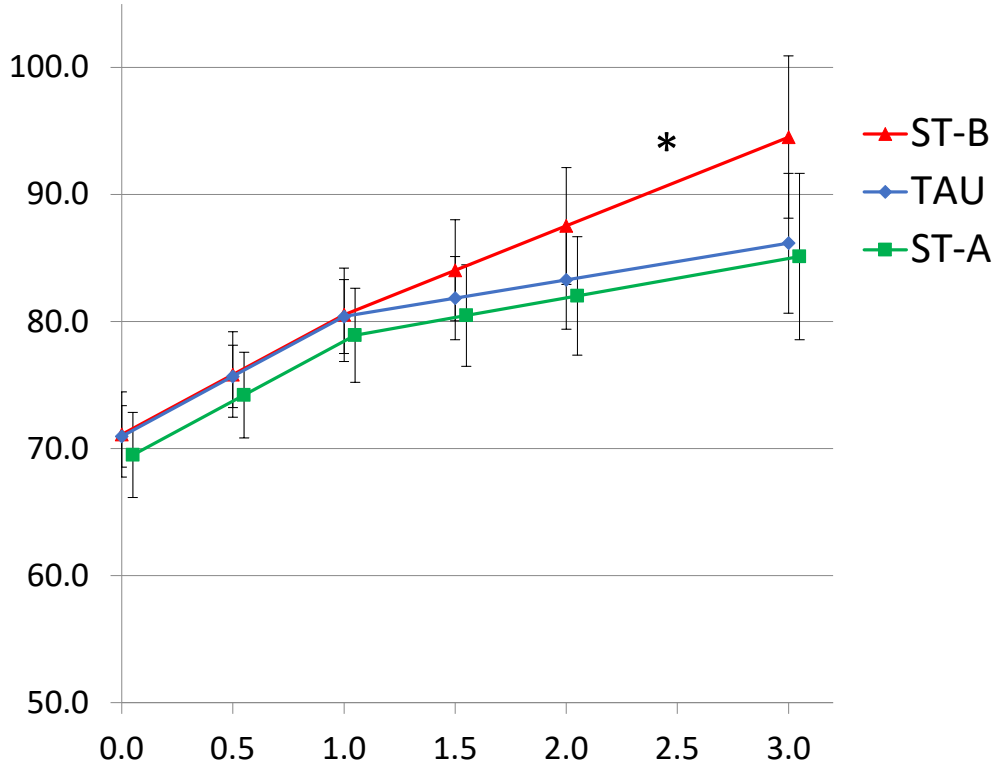
	Cohen's d
ST-B	**1.86**
ST-A	**1.63**
TAU	**1.27**

WSAS
work & social functioning



d
0.65
1.34
1.43

WHOQOL
Quality of Life



	d
ST-B	1.29
TAU	0.84
ST-A	0.86

Conclusies

- Meer inzicht
- Behandelbaar!
  - Goede effecten
- Beschikbaarheid specialistische psychotherapie moet beter
- Lancune: psychotherapie voor BPS & psychose

Dank voor uw aandacht

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