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Personality organization and its association with clinical and functional features in borderline personality disorder

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ABSTRACT

Patients with borderline personality disorder (BPD) show poor psychosocial functioning over the course of their lives. To date, predictors of functionality in BPD patients have remained mostly unexplored. In this study, we aimed to assess the association between personality organization and clinical and functional features in a sample of 50 patients with BPD referred to a specialized outpatient clinic. We used the Structured Interview of Personality Organization (STIPO) to assess personality organization and the Global Assessment of Functioning (GAF) scale to measure functionality. Clinical and demographic associations with personality organization were also explored. STIPO scores were negatively correlated with GAF scores (i.e. higher scores in the STIPO dimensions, which reflected greater personality pathology, were significantly associated with lower psychosocial functioning). After controlling for potential confounders, the STIPO domain “identity” significantly accounted for 26.7% of the variance in the GAF, while the STIPO subscale “sense of self” significantly accounted for 31.2% of the variance in the GAF. These findings suggest that identity and its pathological correlate, identity diffusion, may play a key role in the functional prognosis of BPD patients.

1. Introduction

The psychiatric community's belief that borderline personality disorder (BPD) is a stable and chronic disorder affecting adults has been questioned in recent years. Nowadays, there is solid evidence pointing to earlier onset and a much more heterogeneous course, with high “symptom” remission rates and persistent functional impairment over time (Biskin, 2015; Leichsenring et al., 2011). At the same time, the current categorical diagnosis of BPD has been challenged, with various authors proposing the addition of dimensional personality models to the diagnosis of BPD (Clarkin and De Panfilis, 2013; Gunderson, 2010) and the inclusion in section III of DSM-5 of a criteria-based alternative hybrid model for personality disorders, in which personality functioning has a central diagnostic role (American Psychiatric Association, 2013; Oldham, 2015).

Long-term prospective studies implemented in the last decade in the US have shown that 78–99% of BPD patients achieve sustained

symptomatic remission over time, although approximately half achieve good psychosocial functioning (Gunderson et al., 2011; Zanarini et al., 2012). The Collaborative Longitudinal Personality Disorders Study (CLPS) found that only 21% of BPD patients achieved functional recovery, defined as scores of 71 or higher in the Global Assessment of Functioning (GAF) scale, after a 10-year follow-up (Gunderson et al., 2011). Using a threshold of 61 or higher in the GAF, the McLean Study of Adult Development (MSAD) found that only 40–60% of BPD patients achieved functional recovery after a 16-year follow-up (Zanarini et al., 2012).

Research on predictors of functionality in BPD has been scarce. To date, demographic features such as younger age and higher educational level have been consistently related to better psychosocial functioning (Gunderson et al., 2011; Zanarini et al., 2006), while clinical features such as the absence of hospitalizations prior to the index hospitalization, higher IQ, good previous vocational functioning, absence of a cluster C comorbidity, and high extraversion and high agreeableness

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traits have been identified as predictors to recovery (Zanarini et al., 2014). However, the relationship between the functional outcome of BPD and the core etiological features of the disorder according to the three major evidence-based treatment models (Gunderson, 2016)—emotion dysregulation, mentalizing deficits, and syndrome of identity diffusion—has been mostly unexplored. From the perspective of biosocial theory, higher levels of emotional dysregulation have been related to poorer psychosocial functioning (Wilks et al., 2016), while from the perspective of structural personality organization, lower levels of personality organization have been associated with greater clinical severity of the disorder (Hörz et al., 2010).

The structural personality organization construct is essentially a dimensional model of personality that proposes four broad types of personality organization (normal, neurotic, borderline, and psychotic) (Kernberg, 1967). In this model, borderline personality organization (BPO) is defined by the syndrome of identity diffusion, the pervasive use of primitive defensive mechanisms, and intact reality testing with exceptional alterations related to stressful situations, as well as several manifestations of ego weakness. From a clinical point of view, BPO includes some of the most severe personality disorders, including BPD (Kernberg, 1984). The domains of functioning central to the personality organization model can be assessed using a semi-structured interview, the Structured Interview of Personality Organization (STIPO) (Clarkin et al., 2003).

In this study, we provide a novel approach to the study of structural personality organization by using a dimensional measure such as that provided by the STIPO and focusing specifically on its association with functionality and specific clinical features in BPD. We hypothesized that, among the dimensions assessed with the STIPO, the syndrome of identity diffusion and the predominant use of primitive defenses (i.e. the core features of Kernberg's model) would be significantly associated with poor functionality.

2. Methods

2.1. Participants and data collection

Fifty patients with a presumptive diagnosis of BPD were referred between January and June 2015 to a specialized outpatient unit for evaluation by a consultant psychiatrist specialized in BPD (JLC). The inclusion criteria were age ≥ 18 years, and a confirmed diagnosis of BPD according to DSM-IV criteria after the initial clinical assessment. The exclusion criteria were having a lifetime diagnosis of psychotic, bipolar or organic brain disorder, or being diagnosed in the initial clinical evaluation of a current major depressive episode or mental retardation. 43 patients (86%) fulfilled the clinical diagnostic criteria for BPD after the initial evaluation and were included in the study. Of the seven patients who did not fulfill diagnostic criteria for BPD after the initial clinical evaluation and were excluded from the study, five had a lifetime diagnosis of a psychotic disorder, one had a lifetime diagnosis of a bipolar disorder, and one had a lifetime diagnosis of a non-specified eating disorder.

JLC administered the clinical and demographic questionnaires, the GAF, the CTQ, the CGI-BPD and the SCID II to the 43 patients finally included in the study, while an independent consultant psychiatrist (AE) administered the STIPO. Every scale was administered by a single interviewer, and both interviewers were blind to the results of the assessments they did not conduct. The study was approved by the local ethics committee, and written consent was obtained from all the participants after they received a complete explanation of the study.

2.2. Materials

2.2.1. Assessment of personality organization

We used a Spanish translation of STIPO 1.07, which is a newer and shorter version of the original 100-item STIPO, used mainly in research

studies (Clarkin et al., 2007). STIPO 1.07 has 87 individual items divided into six main domains and eight secondary subscales. Each item is rated from zero (no pathology) to two (clear pathology). The domains and subscales of the interview are “identity” (with three subscales: “capacity to invest”, “sense of self – coherence and continuity”, and “sense of others”); “object relations” (with three subscales: “interpersonal relationships”, “intimate relations and sexuality”, and “internal working model of relationships”); “primitive defenses”; “adaptive coping vs. rigidity”; “aggression” (with two subscales: “self-directed aggression” and “other-directed aggression”); and “moral values”. Domain and subscale scores were calculated according to five-point rating scales, which are rated from one (no pathology) to five (severe pathology) based on scores in the individual STIPO items, the examinee's non-verbal behavior during the interview, and the interviewer's clinical sense of the examinee. The STIPO has shown good psychometric properties both in its English (intraclass correlations 0.96 for identity, 0.97 for primitive defenses; Cronbach's alpha 0.86 for identity, 0.85 for primitive defenses) (Stern et al., 2010), and German versions (intraclass correlations between 0.89 and 1.0 for the STIPO dimensions; Cronbach's alpha between 0.80 and 0.93 for the STIPO dimensions) (Doering et al., 2013). Competent administration requires familiarity with the constructs underlying assessment of personality organization, formal training as a clinical interviewer, and experience administering semi-structured interviews (Clarkin et al., 2007). The psychiatrist who administered the STIPO (AE) received training during a fellowship at the Personality Disorders Institute, consisting in theoretical lessons, and assessment followed by supervision of STIPO video-recorded interviews with trained interviewers. One of the original authors of the interview, John Clarkin, gave his permission for the application of the STIPO in this study.

2.2.2. Assessment of psychosocial functioning

We used the DSM-IV Axis V Global Assessment of Functioning - GAF- score (American Psychiatric Association, 1994) as the measure of functioning in our sample. The GAF scale is based on a continuum between mental health and mental disease and is divided into 100 points, with “100” representing the maximum level of functioning and “1” the minimum level of functioning. We used the GAF scale both as a dichotomous and as a continuous variable. When used as a dichotomous variable, good psychosocial functioning was defined as a GAF score of 61 or higher, because this score offers a reasonable description of a good overall outcome, including at least one significant interpersonal relationship and an acceptable vocational record (i.e. some mild symptoms or some difficulty in social, occupational or school functioning, but generally functioning quite well; has some meaningful interpersonal relationships). This GAF cut-off point of “61” has been used in previous research studies on functionality in BPD (Zanarini et al., 2012).

2.2.3. Clinical assessment

We created a specific clinical questionnaire to assess clinical features - history of non-suicidal self-injury, history of suicide attempts (SA), comorbidity with substance use disorders (SUD - alcohol, cannabis, and stimulants), and attention-deficit hyperactivity disorder (ADHD) - found to be relevant in BPD (Oldham, 2006; Philipsen et al., 2008; Tomko et al., 2014; Zanarini et al., 2011, 2013). We assessed these variables as dichotomous variables (yes/no). Both trauma history and sexual abuse history were assessed based on the Spanish version of the Childhood Trauma Questionnaire (CTQ), which has previously shown good internal consistency reliability (Hernandez et al., 2013) We used the Spanish version of the Clinical Global Impression-Borderline Personality Disorder (CGI-BPD) scale as a measure of clinical severity (Cronbach's alpha 0.85, intraclass correlations from 0.78 for rage to 0.93 for paranoid ideation) (Perez et al., 2007), and the Spanish version of the Structured Clinical Interview for DSM IV Axis II Disorders (SCID II) (First et al., 1999) as a measure of comorbidity with other cluster B

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