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Combined group and individual schema therapy for borderline personality disorder: A pilot study

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ABSTRACT

Background and Objectives: Schema Therapy (ST) is a highly effective treatment for Borderline Personality Disorder (BPD). In a group format, delivery costs could be reduced and recovery processes catalyzed by specific use of group processes. As patients may also need individual attention, we piloted the combination of individual and group-ST.
Methods: Two cohorts of BPD patients ($N = 8$, $N = 10$) received a combination of weekly group-ST and individual ST for 2 years, with 6 months extra individual ST if indicated. Therapists were experienced in individual ST but not in group-ST. The second cohort of therapists was trained in group-ST by specialists. This made it possible to explore the training effects. Assessments of BPD manifestations and secondary measures took place every 6 months up to 2.5 years. Change over time and differences between cohorts were analyzed with mixed regression.
Results: Dropout from treatment was 33.3% in Year 1, and 5.6% in Year 2, without cohort differences. BPD manifestations reduced significantly, with large effect sizes, and 77% recovery at 30 months. Large improvements were also found on general psychopathological symptoms, schema (mode) measures, quality of life, and happiness. Cohort-2 tended to improve faster, but there were no differences between cohorts in the long term.
Limitations: The study was uncontrolled, training effects might have been non-specific, and the sample size was relatively small.
Conclusions: Combined group–individual ST can be an effective treatment, but dropout might be higher than from individual ST. Addition of specialized group-ST seems to speed up recovery compared to only individual ST.

1. Introduction

Borderline personality disorder (BPD) is a severe mental condition, characterized by a pervasive pattern of instability in moods, interpersonal relationships, self-image and behavior. The prevalence is estimated to be 1–2% of the general population and ranges from 10 to 20% among outpatient and inpatient individuals treated in mental health clinics (American Psychiatric Association, 2005). Specific structured therapies have demonstrated efficacy in reducing BPD-symptoms in randomized controlled trials, such as dialectical behavior therapy (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991) and cognitive therapy (Davidson et al., 2006). In the last decade more comprehensive treatments which aim at full recovery have been tested. Various treatments seem promising. Among them is Schema Therapy (ST; Arntz & van Genderen, 2009; Young, Klosko, & Weishaar, 2003). In a multicenter trial in which ST was compared to Transference Focused Psychotherapy (TFP; Yeomans, Clarkin, & Kernberg, 2002) ST turned out to have better treatment retention and to be more effective on various measures (Giesen-Bloo et al., 2006). ST was also more cost-effective than TFP with lower societal costs and stronger effects (van Asselt et al., 2008). A second study demonstrated that ST can be successfully implemented in regular practice, and that telephone availability outside office hours is not necessary (Nadort et al., 2009).

The duration of ST makes the therapy expensive, and problematic to deliver to all patients requesting it. These are compelling reasons to use a group therapy format. Other advantages of group therapy relate to the curative factors as described by Yalom and Leszcz (2005). Among these are universality, getting and giving emotional support, modeling, sense of belonging, practicing interpersonal skills and bonding. Patients can experience the satisfaction of being helpful to others and by doing so bolster their self-

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confidence. An important assumption in working with patients with BPD in groups is that they recognize each other's problems faster and easier than their own problems, and as a consequence patients can validate, support, confront and advise one another. Moreover, patients often experience such responses by other patients as more genuine than when made by a therapist. For these reasons, it has been argued that group-ST might "catalyze" the change processes of ST, thus leading to faster and deeper changes than individual ST (Farrell & Shaw, 2012; Farrell, Shaw, & Webber, 2009).

We developed a protocol for outpatient treatment, in which ST in group was combined with individual ST. We assumed that individual treatment was essential for a number of reasons. We considered individual attention and attachment a basic need of the BPD patient, and it was our opinion that trauma processing is preferably offered in individual sessions, where specific techniques can be used to process painful and disturbing memories, that might be too confronting for other group members. An additional argument is that the combination mimics natural development of attachment with different persons (parent and peers).

During the study, we learned that Farrell and Shaw (2012) had developed a specialized group-ST model, of which a first RCT indicated very strong effects (Farrell et al., 2009). The group process is handled in a very specific way, which demands specific behavior and collaboration of the therapist pair. Our therapists were trained in their method; but the first cohort was already halfway through treatment and the second hadn't started when the training took place. This offered us the possibility to explore whether there were any differences between the two cohorts associated with the use of the Farrell and Shaw model.

2. Methods

2.1. Patients

Patients referred to the Community Mental Health Center of Maastricht, with a primary diagnosis of BPD, based on the Structured Clinical Interviews for the DSM-IV, I and II (First, Gibbon, Spitzer, Williams, & Benjamin, 1997; First, Spitzer, Gibbon, & Williams, 1996; Groenestijn, Akkerhuis, Kupka, Schneider, & Nolen, 1999; Weertman, Arntz, & Kerkhofs, 2000) were asked to participate in the study. If they agreed, they were further screened, by using a semi-structured clinical interview, the Borderline Personality Disorder Severity Index, fourth edition (BPDSI-IV) (Giesen-Bloo, Wachters, Schouten, & Arntz, 2010). If scores were >20, further baseline measurement took place.

Inclusion criteria were: a main diagnosis of BPD, BPDSI-IV score >20, age 18–60, IQ >80 and Dutch literacy. IQ was only tested in case of doubt. Exclusion criteria were: an axis-I disorder that generally needs primary treatment. These were psychotic disorder (except short reactive psychotic episodes belonging to BPD), manic episodes, attention deficit/hyperactivity disorder (ADHD), addiction of such severity that detoxification was indicated (other addictions were not excluded), anorexia nervosa, autistic disorder. Also >2 Narcissistic or >2 Antisocial PD traits were exclusion criteria, as these are likely to be disruptive to BPD group treatment. Males were excluded if they would be the only one in the group. Eighteen women with a primary diagnosis of BPD were included (see Fig. 1 for the consort flow diagram).

2.2. Outcome measures/assessment

The primary outcome measure was the score on the BPDSI-IV, a DSM-IV based semi-structured interview that assesses frequency and severity of BPD manifestations during the last 3 months (Arntz et al., 2003; Giesen-Bloo et al., 2010). The interview is appropriate for repeated measurements and therefore for treatment evaluation. This instrument shows excellent psychometric properties (Cronbach's alpha = .85 in a BPD sample, .96 in a heterogeneous sample; interrater reliability .99; excellent validity and sensitivity to change). The BPDSI has a cut-off score of 15 between patients with BPD and controls, with a specificity of .97 and a sensitivity of 1.00 (Giesen-Bloo et al., 2010). The recovery criterion was therefore defined as achieving a BPDSI-IV score of less than 15 and maintaining this score until the last assessment. An independent research assistant, trained in the BPDSI, administered the BPDSI-IV.

Secondary outcome measures were the following self-report instruments. The BPD-checklist inquires for someone's experienced burden of BPD complaints during the last month (Giesen-Bloo, Arntz, & Schouten, 2006). It is complementary to the BPDSI-IV in the way that it reflects the patients' experienced change, where the BPDSI-IV examines the persons' objective change on BPD symptomatology. The SCL-90 (Derogatis, Lipman, & Covi, 1973) measures subjective distress from a range of psychopathological symptoms. Quality of Life was assessed with the mean WhOQoL Group: Development of the World Health Organization (1998), short version item score, and the thermometer scale of the EuroQoL (range 0–100; Brooks 1996), which assesses primarily subjective physical health state. Happiness was assessed with the 1-item happiness question validated in more than 30 countries, with the following response possibilities: (1) completely unhappy; (2) very unhappy; (3) fairly unhappy; (4) neither happy nor unhappy; (5) fairly happy; (6) very happy; (7) completely happy (Veenhoven, 2008). ST-specific measures were the Young Schema Questionnaire (YSQ; Rijkeboer, van den Bergh, & van den Bout, 2005; Young & Brown, 1994) of which the total score was used; and the Schema Mode Inventory (Lobbestael, van Vreeswijk, & Arntz, 2008; Lobbestael, van Vreeswijk, Spinhoven, Schouten, & Arntz, 2010), of which the mean item score of dysfunctional modes and the mean item score of functional modes was used.

2.3. Treatment and therapists

The treatment protocol consisted of weekly *90-min* group sessions led by two therapists, *combined with weekly 1-h* individual sessions. For pragmatic reasons, group therapists did not have to be the same as the individual therapists. After the first year, the frequency of individual sessions could diminish when therapist, peer supervision group and patient agreed. Individual sessions followed the Arntz and van Genderen (2009) protocol and had the specific aim to support group sessions (e.g., to help with problems patients had in dealing with the group), to deal with crises, and to do extensive trauma processing.

Before group therapy started, some individual sessions were required. In these sessions case conceptualizations in terms of the mode model were made. Patients were prepared by addressing worries patients had about the group. The number of pre-therapeutic sessions differed per patient, from 2 to 12 sessions. Treatment integrity was monitored by means of peer supervision. Therapists were all experienced schema therapists, but none of them had any experience with doing group-ST.

The treatment protocol addressed the theoretical model of ST, different phases of (group) therapy, and ST techniques. Central to the theoretical model of ST in working with BPD is the assumption of 6 schema modes. The distinguished modes in BPD are vulnerable (abandoned/abused) child, angry/impulsive child, punitive parent, detached protector or any other protective mode, and the functional healthy adult and happy child modes. Schema modes are sets of schemas expressed in pervasive patterns of thinking, feeling and behaving. Important goals of ST are to show empathy with and