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## **Burden and diagnosis of personality disorders in adolescents and the effectiveness of Mentalization-Based Treatment**

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This thesis focuses on diagnosing personality disorders (PDs) in adolescents, the burden of disease in adolescents and adults with a (borderline) personality disorder (PD/BPD) and the effectiveness of Mentalization-Based Treatment (MBT). MBT is a treatment for BPD patients that focuses on restoring the mentalizing capacity of patients: the mental process by which an individual implicitly and explicitly interprets the actions of himself and others as meaningful on the basis of intentional mental states such as personal desires, needs, feelings, beliefs, and reasons. These severe impairments in mentalizing often result in emotional instability, impulsive behaviour, and vulnerability in interpersonal and social interactions. Improving this capacity is therefore thought to be associated with a reduced need to rely on maladaptive coping strategies to deal with feelings of inner emptiness, impulsivity and conflicts in interpersonal relationships, and therefore to lead to the mitigation of symptoms and the enhancement of interpersonal functioning.

**Chapter 1** discusses the dearth of research on PDs in adolescents despite it being known that PDs in adolescents can be diagnosed reliably, and that the prevalence in both the community and this treatment population is high and comparable with that in the adult population. Professionals in mental health care seem reluctant to diagnose PDs in adolescents, and so these disorders are probably underdiagnosed in this group. These adolescents may therefore only receive appropriate treatment at a later stage when a lot of damage already has been done. In addition, there is a scarcity of evidence-based and effective treatment models for adolescents with PDs. In this thesis we aim to remedy this knowledge gap and to raise awareness of PDs in adolescents. More specifically, we focus on the seeming reluctance of professionals in mental health care to diagnose PDs in adolescents and on the burden of disease for these patients, and we describe a pilot study for the treatment for adolescents with PDs.

A lot more research has been performed on PDs in adults, and particularly on borderline personality disorder (BPD) since the latter is one of the most common mental disorders in psychiatric populations. For a long time, the focus of treatment for BPD was on very intensive treatments with the aim of losing a standardized diagnosis of BPD and on improving symptomatic outcomes such as self-harm and parasuicidal behaviour. However, interpersonal functioning and vocational adaptation remained impaired after intensive treatment, especially in patients

with a severe PD such as BPD. There is therefore some debate about whether very intensive treatment for BPD patients is the best approach for these severely disturbed patients since it is very hard for patients to improve their social skills outside the treatment room when they are in treatment wards for five days a week. This has resulted in a new theoretical development, salutogenesis, the capacity to learn and derive benefit from the (social) environment. In addition, very intensive treatments for BPD are also expensive, and the current climate of cuts in medical cover threatens access to these treatments. As a consequence, very intensive treatments for BPD now need to be compared with less intensive treatment forms. This thesis compares very intensive treatment for BPD (Day Hospital Mentalization-Based Treatment; MBT-DH) with specialized treatment as usual (S-TAU). We also calculate the burden of disease in patients eligible for MBT as this is treatment for BPD patients at the most severe end of the continuum.

## PART I: PERSONALITY DISORDERS IN ADOLESCENTS

**Chapter 2** discusses the impact on actual clinical practice of practice guidelines for diagnosing PDs in adolescents. Our results indicated that a majority of a sample of 566 psychologists, 367 of whom reported working with adolescents, acknowledged the existence of PDs in adolescents. However, only a small minority of the psychologists diagnosed PDs in adolescence and an even smaller percentage offered treatment specifically targeting PD pathology. The reasons for not diagnosing PDs in adolescence were mainly related to the belief that adolescent personality problems are transient and that the DSM-IV-TR does not allow for the diagnosis of PDs in adolescence. As a consequence, although practice guidelines may have influenced clinicians' opinions about PDs in adolescence, they have had little impact so far on routine clinical practice.

**Chapter 3** looks at the burden of disease in 131 adolescents with personality pathology in terms of quality of life and societal costs. These adolescents reported poor quality of life, with a mean EQ-5D index value of only 0.55. This study also showed that these adolescents generate high societal costs. The mean direct medical costs in the year prior to treatment were €14,032 per patient. The burden of disease was comparable with the burden of disease in adult PDs. The high burden of disease in adolescents therefore constitutes a strong argument

for the development of effective – and cost-effective – treatments for this patient population.

**Chapter 4** therefore looks at whether MBT-A could be a feasible treatment for adolescents with borderline symptoms. MBT for adults was adapted for adolescents in a clinical setting. The participants were eleven female adolescents aged 14-18 years. The maximum treatment duration was twelve months and patients were assessed at the outset and twelve months after the start of treatment. The results indicated a significant reduction of symptoms and improvements in personality functioning and quality of life twelve months after the start of treatment. We conclude that the results of this feasibility study are promising and encourage further research into the efficacy of MBT in adolescents with borderline symptoms. Nevertheless, given the implementation problems in the current study, we also suggest that less intensive, more outreaching MBT-A may be more effective and easier to implement.

## PART II: BORDERLINE PERSONALITY DISORDER IN ADULTS

**Chapter 5** shows that the 403 patients included in this study reported a mean EQ-5D index score of .48, which represents poor quality of life. The mean total costs in the year prior to treatment were €16,879 per patient, 21 percent of which consisted of productivity costs. The burden of disease in BPD patients who are eligible for MBT is therefore high, making it more likely that society will be willing to invest in treatment for these patients. However, this finding should not be interpreted as a license to use resources without restraint to fund treatment for severe BPD patients since these findings do not provide any information about the effectiveness of MBT or other treatment programmes available for BPD.

**Chapter 6** outlines the research protocol for a multi-site randomized trial comparing the effectiveness of MBT-DH with manualized specialist treatment as usual (S-TAU). The MBT-DH programme consisted of a maximum of eighteen months of intensive treatment, followed by a maximum of eighteen months of maintenance therapy. S-TAU was provided by the City Crisis Service in Amsterdam,

and treatment was tailored to the individual needs of patients. Patients were assessed at baseline and subsequently every six months until 36 months after the start of treatment. The primary outcome measure was the frequency and severity of manifestations of BPD. Secondary outcome measures included symptomatic distress, social and interpersonal functioning, and quality of life.

**Chapter 7** presents the results of the study comparing MBT-DH and S-TAU after eighteen months of follow-up: both treatments led to significant improvements in all outcome variables, and MBT-DH was not superior to TAU. In addition, although presenting BPD patients with the option that their treatment will be tailored to their specific needs may be appealing, the lack of a clear treatment plan including frequency and length may have a negative impact on the engagement and motivation of patients with BPD. Yet, at the same time, the implementation of MBT-DH in a new setting may be challenging, as it may threaten the coherence and consistency of the treatment approach, which may mitigate treatment effects. In this respect, this study may have underestimated the effectiveness of MBT. More positively formulated, however, this study suggests that MBT, as delivered by therapists that are new to the model and that receive a 2-day training and regular supervision, is associated with similar effects as a well-established treatment service offering other evidence-based interventions for BPD patients. This finding may have important implications in terms of cost-effectiveness of training and service delivery in this area. Further research into these issues is needed, as well as studies of the cost-effectiveness and long-term outcome of both treatments.

## PART III

**Chapter 8** contains the general discussion and summary of the research findings of this thesis. It also reviews the implications for clinical practice and future research. We conclude that early recognition and early intervention are essential for adolescents with PD to ensure they receive optimal care. If clinicians do not take PD features in adolescents seriously, the adolescents will not receive appropriate treatment for their disorder. Clinicians in routine clinical care should learn how to recognize a PD to make early intervention possible. Clinical staging could provide professionals in mental health care with an acceptable framework for the treatment of adolescents with BPD. Moreover, clinical staging may provide

a focus for developing new interventions. Future research should target the development and implementation of the clinical staging model and the most appropriate intervention for each stage of a disorder. In the field of treatment for adult BPD, we are currently witnessing a paradigm shift from very intensive, to less intensive and more generalist, treatment models. Given limited resources, we should be making optimal use of the available resources such as funding and the number of highly trained professionals. This pragmatic approach means that we have to deliver some generalist care, and some specialist care. This should make BPD treatment more accessible. Generalist models for the treatment of BPD should be implemented in institutes for general mental health care and their effectiveness and cost-effectiveness should be investigated.