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Perceived Feeling of Security: A Candidate for Assessing Remission in Borderline Patients ?

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Second revision

Perceived feeling of security: A candidate for assessing remission in borderline patients?

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Running title: Perceived security by borderline patients

Abstract

The aim of the study was for the first time to examine whether adults diagnosed with Borderline Personality Disorder feel that their sense of security improved through treatment with Dialectical Behavioral Therapy conducted one or two years earlier. In the current study perceived security was defined as a feeling of being free of worrisome or threatening phenomena. Twenty-three patients (2 men and 21 women) aged 18 to 57 years, were recruited from five teams in Southwest Sweden. A questionnaire was constructed where responses were given on visual analogue scales. There were three questions about security, namely perceived security when completing the questionnaire as well as estimated perceived security before and after treatment. The three questions were embedded among 19 other questions which dealt with various aspects of quality of life. Results indicated three main results: (a) the patients reported being feeling more secure following the treatment, (b) mental health of the patients and their health in a broader view appeared to be decisive for the perception of security and (c) the perception of greater security remained one or two years following treatment. The conclusion was that perceived feeling of security might be able to add a new dimension to currently used ways to assess the effects of the treatment of borderline patients and it might also be considered to be included in a future concept of borderline remission.

Key words: Borderline personality disorder, cognitive behavior therapy, dialectical behavioral therapy, mental health, remission, security, quality of life.

INTRODUCTION

An individual with Borderline Personality Disorder (BPD) is an intensely emotional person who has difficulties dealing with his/her strong emotional reactions. BPD has been characterized in DSM-IV as a "pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity" [1, page 706]. These patients have problems with trust [2] and for this reason, it may be difficult to obtain sincere responses from a patient regarding e.g., his/her mental health or perceived security prior to treatment and before an alliance has been established. For this reason, great effort is used to establish the alliance between the therapist and the client during treatment. The foundation of the alliance is established during the initial phase and can be compared to early childhood when attachment behavior is viewed as particularly important according to attachment theory [3]. In a review article of 13 empirical studies examining different types of attachment found in adult individuals with BPD or with dimensional characteristics of BPD [4] the researchers found a strong association between BPD and insecure attachment in all of the studies. Unresolved, preoccupied and fearful types of attachment indicated feelings of worry and threat. The BPD participants in the 13 studies demonstrated feelings of insecurity when they at the same time longed for intimacy and had concerns about dependency and rejection. The significant prevalence of insecure attachments found in these adult samples underscores the need for attachment in terms of a functional alliance. That attachment then constitutes the platform for personal security, a fact of particular importance to a patient with BPD [4]. With the secure platform of the alliance as a starting point, the patient may then gradually explore his/her environment and be trained to develop trust and confidence.

There now exist successful therapeutic techniques for the treatment of BPD [5] and strong support for Dialectical Behavioral Therapy (DBT) has been reported in a systematic review conducted by Cochrane Collaboration [6]. Dialectic Behavior Therapy is one of those types of therapy often referred to as "the third force CBT" [7, 8]. DBT has its foundation in learning theory, cognitive theory, the philosophy of Zen Buddhism in which training in mindfulness is central as well as dialectical philosophy ranging between the two poles of acceptance and change. The method was developed by Linehan [9] and was originally designed to help suicidal women with the diagnosis of borderline personality disorder. In four randomized and controlled studies (RCT) it was shown that DBT was superior to treatment-as-usual regarding a series of outcome parameters [10]. In most cases the improvements remained after a one-year follow-up [10, 11, 12]. Among the outcome parameters in studies of BPD treated with DPT, there have been a series of parameters such as a decrease in the number of parasuicidal acts, better retention in self-damaging behavior, a decrease in impulsive behavior, improved coping strategies, enhanced perceived life satisfaction as well as improvements regarding depression, dissociation, anxiety and global distress [5]. Individuals with emotional labile personality disorder possess several personality traits which strongly indicate a need for predictability and security in chaotic environments [13]. Despite comprehensive searches in data bases, we have not been successful in finding studies where the focus has been how patients with BPD perceive security as being associated with health, well-being, and quality of life following therapy.

Security is a multi-faceted concept as shown in various studies. Security may for example be associated with personal safety in studies of environmental investigations [14]. In studies focusing on quality of care and treatment relationships, security is often associated with patient safety [15, 16]. Furthermore, the contents of the concept and its relation to quality of care may be defined in terms of predictability and consistency in the process of the patient [17]. A

contributing factor to the perceived sense of insecurity of the patient has been shown to be associated with a sense of lack of predictability. A lack of predictability takes the shape of not knowing what is to come thus implying that predictability assumes consistency. An increase in strategies for dealing with patients and their treatment thus entails an increase in the predictability in the patient process as a whole from the time of admission to the time of release, which in turn also implies an increase in security [17].

In the Swedish language, the concept of security is divided into two dimensions; (a) security associated with one's life, in interaction with the environment (i. e., "säkerhet") and (b) security as a feeling (i. e., "trygghet"). The security in one's environment, according to Segesten [18], entails knowledge and faith in one's ability to predict deal and control one's environment as well as not being subjected to actual threats. In such a secured and controlled environment (säkerhet) it is possible for feelings of security (trygghet) to thrive. The feeling of security entails life quality aspects such as balance, warmth, happiness, luck, calm, harmony, peace of mind, grounding, trust, rest, ease, and liberation of energy [18]. Also included in that category, there is the notion that includes community, belonging, permission, responsibility, norms and ideals, as well as permission to confess weakness and having trust in oneself. That latter part may be built through positive experiences, conscious work with insecurity and through working one's way through a crisis. Security may be seen both as a phenomenon and an experience, given that in the real world one may find and create the premises for security, but the security itself or lack thereof, are the individual person's own perceptions. In the current study, security is defined according to Segesten in regard to the second dimension [18] as "*a perceived feeling of being free of worrisome or threatening phenomena*". For a BPD patient this would indicate feelings of being free from a lifelong pattern of behavior "which may include unclear and disturbed self-image, brief psychotic episodes, involvement in intense unstable relationships, repeated emotional crises, fear of abandonment and a series of suicidal threats or acts of self-harm without apparent cause" [19].

Feelings of security are an important aspect of health and for this reason, it should include associated parameters such as the quality of life of patients and caregivers, sustainable change, treatment satisfaction and job satisfaction which ought to be assessed within medical and health care [20]. In a review article [21] with 35 phenomenological studies of health, it was shown that health was closely associated with well-being and quality of life. This finding is in line with several quantitative studies which also reported associations between health, quality of life, satisfaction with life [22, 23]. Further confirmation of such associations was given in a review article of 38 international studies [24] showing that a reduction in well-being is strongly associated with mental ill health. Furthermore, it showed that in most mental disorders a reduction of well-being is strongly associated with mental ill health and in most mental disorders those affected exhibited a reduced quality of life. In sum, the studies show that health may be a decisive factor regarding how satisfied or dissatisfied with life a person may be. It has also been shown that the reverse association may be true [25, 26], thus, a feeling of satisfaction leads to an improvement of the state of health.

The questions posed following the review of the literature are how individuals diagnosed with borderline personality disorder (BPD) view their feeling of security before and after treatment with DBT two years after their treatment. Do they feel that it improved following treatment? How is feeling of security perceived one year or two later? Is it at the same level or has it changed? How is their feeling of security related to their perceived mental and health?

Purpose

The purpose of the current study was to examine if individuals diagnosed with BPD perceive that their feeling of security improved through treatment with DBT conducted one or two years earlier.

MATERIALS AND METHODOLOGY

Participants

Participants included in the study were 23 patients (2 men and 21 women) aged 18 to 57 years, have been recruited from five DBT teams in Southwest Sweden. Following testing they were all diagnosed with Borderline Personality Disorder (BPD) in accordance with symptom criteria in DSM IV. Of the total of the 23 patients, 14 were on ongoing medication, while nine were on no medication. Finally 14 of the patients were working while 9 were unemployed.

Instrument

A questionnaire was constructed to examine if the patients felt that their perceived feeling of security had changed due to treatment and to explore whether the participants' perceived satisfaction following DBT treatment had changed on the basis of subjective indicators of quality of life. The Swedish word "trygghet" was used for items dealing with security because there is a consensus view among Swedes about the meaning of the word [18]. There were three questions about feelings of security, namely "How secure do you feel in your environment?" "How secure in your environment did you feel prior to treatment", and "How secure did you feel in your environment following treatment?" The three questions were embedded among the other questions so that it was not obvious that they would play a particular role in the data analysis. In addition to the three questions on security, there were 19 questions that dealt with various aspects of quality of life, and among them three questions regarding whether any mental, general, and physical aspects of health had improved following treatment according to DBT. The questions were constructed against the background of results of previous research related to health related quality of life [22, 23]. The responses were given as a check on a VAS scale (Visual Analogue Scale) with a length of one decimeter with scale points 0-100. As "anchor-points" obvious markings were used such as "Not at all – Very much", "Not at all satisfied – Very much satisfied", and "Not at all secure – Very secure". A reliability testing using the Guttman Split-Half Coefficient yielded a quotient of 0.86. Another reliability test (Guttman Split-Half), this time including only the three items dealing with perceived feeling of security, resulted in an acceptable quotient of 0.70. Since involvement in intense unstable relationships is a core issue in attachment theory as well for BPD patients the question concerning perceived feeling of security at the time of the completion of the questionnaire was correlated (Pearson's r) with those test items which specifically dealt with relations (5, 6, 18). The analysis yielded significant correlations ($r = 0.46$, $r = 0.41$, and $r = 0.53$) which validated the rationale of the questionnaire. Finally, the questionnaire also contained several demographic questions e.g. gender distribution,

age span, information regarding work and whether the patients were on medication. The 22 questions are listed in Table 1 in the order as presented in the questionnaire along with means and standard deviations.

Table 1. The questionnaire questions, with means (*M*) and standard deviations (*SD*).

Question	<i>M</i>	<i>SD</i>
1. How satisfied are you currently with your life?	59.35	23.17
2. How satisfied are you with your general health?	52.87	22.29
3. How satisfied are you with your physical health?	49.00	22.47
4. How satisfied are you with your mental health?	54.36	30.36
5. How satisfied are you with your family life?	64.59	30.50
6. How satisfied are you with your social relationships?	54.73	25.50
7. How satisfied are you with your living arrangements?	65.41	28.50
8. How secure do you feel in your environment?	72.06	23.01
9. How satisfied are you with your work?	59.50	35.28
10. How satisfied are you with your financial situation?	33.95	28.04
11. How satisfied are you with your income?	24.14	25.86
12. Are you satisfied with your life?	57.44	26.86
13. Has your general health improved following your DBT treatment?	69.35	33.40
14. Has your physical health improved following your DBT treatment?	45.87	32.13
15. Has your mental health improved following your DBT treatment?	73.83	29.24
16. Do you receive ongoing medical care for your mental health?	39.96	30.50
17. Has your family situation improved following your treatment?	56.22	35.24
18. Have your social relationships improved following your treatment?	61.48	27.86
19. How secure did you feel in your environment <i>prior</i> to your treatment?	22.57	21.78
20. How secure did you feel in your environment <i>following</i> your treatment?	62.65	26.89
21. Has your treatment affected your work situation?	57.70	36.68
22. Has your treatment affected your financial situation?	25.26	30.97

Design

The DBT teams participating in the study work in accordance with "standard DBT" implying that all parts of the treatment are included. The patient then has individual therapy once per week for approximately 45 minutes and the patient also participates in a so-called skills-training group for 2-2.5 hours per week. During periods of active self-destructive/suicidal behavior so-called Phase 1 work is included with the possibility of telephone coaching between the individual therapist and patient. What the conditions of this treatment intervention are clearly spelled out to the patient ahead of time. The purpose is for the patient to ask for help before problem behavior arises and to receive help generalizing the behaviors taught in the group. In the skills training which most often takes place in the group, the individual among other things learns to change behaviors, regulate emotions, identify thought content that gives rise to difficulties and internal pain. Skills training contains four modules, namely to (a) be attentive and present in the moment, (b) to create and maintain good relationships with others, and (c) to regulate one's emotions, and (d) to endure during difficult situations without succumbing to destructive behaviors. The purpose of the skills training is to train the individual to contribute herself to creating a more stable and more secure environment.

It takes about one year to work through this material. The patient may often need to go through the material twice. At the same time, the patient is in individual therapy where help is given and support for the application of newly acquired skills. In the individual therapy, the behavioral analysis is central to identifying problem areas, making serial analyses of those areas which lead to the possibility of seeing the consequences in the short and the long run. In the behavioral analysis, the therapist and patient together try to identify possible triggers that may give rise to different dysfunctional behaviors. In the analysis, one gives attention to possible vulnerabilities that may exist. It could for example be that the person may have eaten or slept too much or too little. It could also be that the person has used alcohol or drugs. In the serial analysis one also adds the individual's thoughts, feelings, and bodily sensations. Together one is to find possible problem solving techniques, often found among the new skills taught in the group work. The patient is given help in this way to find alternatives to various dysfunctional behaviors. By doing this the patient solves problems that arise instead of possibly harming herself. The time of treatment for the individuals in the study varied from single individuals attending skills training for one year or as much as two years with individual therapy in parallel.

Procedure

Five DBT teams in Southwest Sweden who had had patients in DBT treatment were contacted, namely the teams in the cities of Halmstad, Varberg, Kungsbacka, Borås, and Kungälv. In connection with the contact, consent was also received from all the clinical directors that the study could be conducted on their team. The condition placed on the selection was that all of the participants had participated in a complete DBT treatment, and that one or two years should have passed since the end of treatment. Furthermore, it was decided that approximately five participants per DBT team would constitute a sufficiently representative base. The questionnaire, a letter of information as well as a stamped response envelop were distributed to the patients who met the criteria of inclusion, and when 23 questionnaires had been received by the two students pursuing the psychotherapist degree responsible for the conduction of the study, recruitment was ended.

Ethical considerations

Before the study was conducted consent was obtained from the responsible head of each team to conduct the study in the way planned. In addition, the study procedure was reviewed and approved by the ethical research committee at Evidens University College. The five participating teams each received envelopes that they were supposed to distribute by mail to patients who corresponded to the inclusion criteria. In the envelope was in addition to the survey a stamped envelope addressed to one of the two students and also an accompanying letter addressed to prospective participants which informed that the purpose of the study was to examine if the experience of quality of life of the participants had changed following the DBT treatment. It was also clear that participation in the study was voluntary and confidential, and that participation would not affect other possible ongoing treatments. Finally, the participants were informed that the study would be published as a degree paper within the therapy training program. The patients had access to contact information regarding the two students who conducted the study while personal information regarding the patients was protected vis-à-vis the researchers since the DBT

teams were responsible for submitting the questionnaires. Patients who decided to participate in the study simply sent their questionnaires directly to the students. In this way, the teams did not know which patients participated in the study and the two students had no information concerning how many envelopes each team actually distributed or from what clinics the participants came from or their names. In this way total anonymity was secured. Patients who wanted to participate showed their consent through just submitting the questionnaires.

RESULTS

The security questions

The security questions appeared in the questionnaire as numbers 8, 19 and 20 (see Table 1). Number 19 was to indicate how secure the patient felt prior to treatment, whereas number 20 was to indicate how secure the patient felt following treatment. Number 8 however indicates how secure the patients felt at the time of completing the questionnaire. Perceived feeling of security at the time of the completion of the questionnaire correlated (Pearson's r) with perceived security following the DBT treatment ($r = 0.60$, $p = 0.003$), while there were no significant correlations between those two variables and perceived security *prior* to the DBT treatment ($ps > 0.05$). Paired Samples t-test (5 % level) yielded a significant difference between perceived feeling of security before the DBT treatment ($M = 22.57$, $SD = 21.78$) and perceived feeling of security after the treatment ($M = 62.65$, $SD = 26.89$) [$t(22)$, $p < 0.001$]. There was no significant difference between perceived feeling of security at the time of the completion of the questionnaire ($M = 72.06$, $SD = 23.01$) and perceived feeling of security following treatment ($p = 0.098$).

Regression analysis

In order to examine which aspects of the quality of life affect the variance in terms of perceived feeling of security a step-wise linear regression analysis was conducted with perceived security at the time of completion of the questionnaire (question 8) as the criterion variable and with all the questionnaire questions except perceived security following DBT treatment (question 20) and age, medication, and work as predictor variables. The analysis showed that two predictor variables affected the criterion variable significantly [Step 1: $Adj R^2 = 0.38$, $F(1, 20) = 13.65$, $p = 0.001$; Step 2: $Adj R^2 = 0.52$, $F(2, 19) = 12.18$, $p < 0.001$]. In the first step the variable (question 15) "Has your mental health improved following the DBT treatment?" and in the second step (question 13) the variable "Has your general health improved following DBT treatment". Thus, the two predictor variables predicted 52 % of the variance of the criterion variables. Question 15 correlated with the criterion variable ($r = 0.64$, $p = 0.001$) as did question 13 ($r = 0.46$, $p = 0.029$). This fact can be compared to the notion that there were no significant correlations regarding the two variables indicating physical health ($ps < 0.05$).

Comparisons among groups

Less perceived feeling of security vs more perceived feeling of security. In order to examine if there were differences between patients who responded with less security at the completion of the questionnaire compared to those who responded higher, the variable was categorized according to the appearance of the distribution (*cut off* = 65) in a lesser group ($n = 8$, $M = 47.63$, $SD = 16.40$) and a more group ($n = 14$, $M = 86.00$, $SD = 11.56$). Statistics using the Mann-Whitney U-test (5 % level) showed that the group displaying less on question 8 also responded to a lesser degree on all other questions ($ps < 0.05$) with the exception of the question 3, 6, 7, 14, 17, 18, 19 and 22 ($ps > 0.05$) where perceived feeling of security at the time of the completion of the questionnaire seemed to play a lesser role regarding how the questions were judged.

Medication. Nine of the patients were not on medication whereas 14 were on medication. Statistics using the Mann-Whitney U-test (5 % level) showed only one significant difference between those who were on and those who were not on medication ($M = 21.78$, $SD = 22.33$), namely on question 16 ($p < 0.05$), indicating that those who were not on medication reported that they were receiving medical care to a lesser extent than those who were on medication ($M = 51.64$, $SD = 29.86$). There were no other significant differences between those who were on and those who were not on medication ($ps > 0.05$).

Age. Fourteen of the patients were between 18 and 33 years old (Younger) and 9 were between 34 and 57 years old (Older). Statistics using the Mann-Whitney U-test (5 % level) yielded only one significant effect ($p < 0.05$), for question three. The younger patients reported being more satisfied with their physical health ($M = 57.71$, $SD = 18.75$) than the older patients ($M = 35.44$, $SD = 21.85$). There were no other significant differences between the younger and older patients ($ps > 0.05$).

Work. Nine of the patients were unemployed and 14 had a job. Statistics using the Mann-Whitney U-test (5 % level) yielded significant effects for the questions 1, 2, 6, 9, 12, 13, 14, 15, 16, 17, 18, 20, and 21 ($ps < 0.05$) where those who had a job reported higher values than those who did not with the exception of question 16 where the result was the opposite. There were no other significant differences between those who had a job and those who did not ($ps > 0.05$).

DISCUSSION

The current study yielded three main results: (a) the patients reported being feeling more secure following the DBT treatment, (b) two aspects of health appeared to be decisive for the perceived feeling of security i.e., the mental health of the patients and their health in a broader view, and (c) the feeling of greater security remained one or two years following treatment.

The patients reported their perceived feeling of security before and after the DBT treatment at a time when one or two years had passed since the end of treatment. There was also a question embedded in the questionnaire concerning how secure they felt in their environment. The purpose of that question was to serve as a comparison vis-à-vis the other two security

questions. The result indicated that there was no significant difference between their perceived feeling of security following treatment and their security at the time of the completion of the questionnaire. There was however a significant difference between their perceived security before the DBT treatment compared to both following treatment and at the time of the completion of the questionnaire. That finding suggests that there is a consistency in the patients' perception of security, and the results of their ratings suggested a marked difference between their degree of perceived security before and after the treatment. Their ratings increased more than 40 units of percent. Earlier studies have shown that DBT treatment may be advantageous for patients with BPD, in particular with regard to high-risk behaviors [5], and the current study indicated for the first time that the concept of feeling of security might be considered as an outcome parameter.

The concept of feeling of security, i.e. *feeling free of worrisome or threatening aspects of life*, comprises a large number of variables such as physical and mental health, security in the environment, satisfaction with one's life, family life, social relationships, work, income, and finances. The analysis showed that the perception of mental and general health was decisive in determining how secure the patients felt they were at the time of completion of the questionnaire. The perception of mental health was responsible for almost 40 % of the variance in the perceived feeling of security and taken together the two variables contributed to approximately half of the variance. It is interesting to note that a majority of the participants perceived significant improvements in terms of mental health in particular as a result of the DBT treatment. It was that questionnaire question, along with the question on perceived feeling of security at the time of the completion of the questionnaire which clearly received the highest values. The strong association between feeling of security and mental health is in line with several previous studies [4]. Two of the questions concerned physical health and on average the participants did not feel that it was affected by the treatment, either positively or negatively to a large extent, and it was not significantly associated with the perceived feeling of security.

The participants completed the questionnaire between one and two years following the end of the DBT treatment. The results showed that there were no differences between their perceived feeling of security following the DBT treatment and the perception of security at the time of the completion of the questionnaire. Given the high means for security in the current study there is no doubt that the participants perceived good security despite the fact that on average about one and one half years had passed since the treatment. This fact is in line with previous studies that show that improvements as a result of DBT treatment are maintained for the most part after a one-year follow-up [10, 11, 12]. Which mechanisms might be underlying the fact that the patients in the current study perceived continuous good feelings of security despite the time passed since the end of treatment? A central component of dialectical behavior therapy (DBT) is to teach specific behavioral techniques with the purpose of helping the individual with borderline personality disorder (BPD) replace maladaptive behavior with functional skills. In one study the researchers [27] found that the participants treated with DBT employed three times as many skills at the end of treatment than before the treatment compared to a control group. The use of skills also indicated a reduction of suicide attempts, depression, and an improved control of aggressiveness. In a different study [28] an increase in the use of skills pointed to a reduction of symptoms regarding the more specific BPD related symptoms such as emotional lability, problems of identity, and relational difficulties. DBT treatment is geared toward offering various strategies, skills to train the individual to become better equipped for handling crises in life. The individual is trained to understand sequences of events, to analyze them, not only intellectually but also emotionally without acting out the emotional behavior in a dysfunctional way. Instead their problem solving ability is trained, the ability to see the consequences of behaviors in the

short run and the long run. Most likely, these new skills provide the individual with an improved ability to maneuver his/her environment, a fact that will lead to better control and to contribute to an increased security.

A number of group comparisons were made in the current study. The outcomes were predicted and further underscored the consistency of the responses of the participants. The first comparison concerned a comparison between those participants who gave a lower value on perceived feeling of security (although not low but rather an average level) and those who responded with a very high perception of security. In addition to the fact that there were no differences regarding the questions on physical health, it can also be noted that there were no differences between the groups regarding perceived feeling of security *prior to* the DBT treatment. The very low value on perceived security before the treatment indicates that the participants of the study initially had a very low level of security regardless of whether following treatment they ended up on an average level or very high level of perceived security. Another group comparison was made between those who were on medication and those who were not at the time of the completion of the questionnaire. There were no differences between the groups except the obvious difference that the patients who were not on medication to a lesser extent received ongoing medical care. An additional comparison was made between younger and older participants and the only significant difference was that the younger participants reported that they were that they were more satisfied with their physical health compared to the older participants. Finally, one comparison was made between those participants who had a job and those who did not. The analysis confirms previously known findings that employment makes a difference. On 60 percent of the questions the employed participants reported that they were more satisfied in a number of ways compared to those who were unemployed.

The current study had certain limitations. It would have been desirable to have included more participants and of course a more equal gender distribution. In addition, it would have been an advantage if the measurement instrument had been tested on patients during different phases of the DBT treatment. However, despite those limitations, the study was the first to show that perceived feeling of security might be an important parameter with which to describe the effect and duration of therapeutic treatments of patients with emotional labile personality disorder. It may be of importance to offer a new suggestion of an outcome parameter, given that there exists a certain amount of diagnostic confusion regarding BPD since DSM has a long list of criteria that is not always internally logical [29].

A diagnostic complement to DSM might be The Revised Diagnostic Interview for Borderlines which contains 22 symptoms. They are grouped into four sections of psychopathology which need to be present for the diagnosis of borderline [29]: (a) Affective (extreme moodiness; chronic feelings of emptiness; frequent feelings of anger or frequent angry acts), (b) Cognitive (serious identity disturbance; stress-related paranoia or dissociation), (c) Behavioral (suicide threats, suicide attempts, or self-mutilation; at least two other forms of impulsive behavior), and (d) Interpersonal (frantic efforts to avoid abandonment; unstable relationships marked by alternating between idealization and devaluation of attachment and withdrawal).

Within the area of schizophrenia, there is agreement regarding measurement instruments and criteria for remission [30, 31]. However, for this to be possible within the area of borderline personality disorders, most comprehensive, continued longitudinal research, already begun in large scale prospective studies is needed [32, 33]. The concept of perceived feeling of security might be able to add a new dimension to the currently used ways to assess the effects of the treatment of borderline patients, namely by elucidating perspectives on attachment theory and the

interactions of individuals and monitoring of one's environment in order to master disquieting and threatening episodes.

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CONFLICT OF INTEREST

The authors confirm that this article content has no conflict of interest.

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