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Changing life stories: how treatment affects communion by people with a personality disorder

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Abstract

Background: Social relations with others, including feelings of unity, solidarity and attachment (communion), are a fundamental part of humans' everyday lives and necessary for personal growth and wellbeing. This study investigates the life stories of patients with personality disorders in order to compare their (positive and negative) schemes of social experiences before and after a cognitive-behavioral clinical treatment. The purpose of this study is to examine to what extent treatment is related to positive changes in patients' life stories of their social experiences.

Methods: In order to evaluate the various manifestations of the theme communion in the patients' life stories, a qualitative analysis was conducted. For the qualitative analysis, a codebook was developed, using a deductive and an inductive approach. By means of the codebook and the software program Atlas.ti (8), it was analyzed whether the quality of the theme communion changed during treatment. A paired samples t-test was conducted to analyze whether the differences of the main codes of communion before and after the treatment are significant.

Results: The theme communion is present in the life stories in various manifestations. The patients mention in their stories experiences concerning the presence of others, the feeling of being attached to others and to interact with empathy (presence of communion). Moreover, the patients also mention experiences concerning a lack of others and attachments (absence of communion) and traumatic experiences. Patients also mention experiences with "too much" communion. It is striking that the content of the life stories, written after treatment, is more future-oriented and self-referential, compared to the stories written before treatment. In addition, the patients attribute diverse meanings to their experiences with communion. Based on the results of the quantitative analysis, it can be concluded that there are no significant changes during the treatment in the presence of communion, absence of communion and too much communion in the life stories of the patients.

Conclusions: Using the narrative approach to evaluate the theme communion in life stories is an appropriate way to analyze whether dysfunctional (interpersonal) schemes of patients changed during treatment. The results of this study can be used to encourage the patients to draw attention to their different (negative and positive) schemes they can have about social relations, in order to foster a more positive attitude towards themselves and others. Additional studies are needed to investigate the differences between the life stories and the theme communion of healthy persons and those with a personality disorder.

1. Introduction

Social relations with others, including feelings of unity, solidarity and attachment (communion), are a fundamental part of humans' everyday lives and necessary for personal growth and wellbeing. People with personality disorders often have adverse beliefs regarding themselves and others, which leads in many cases to problems and misconceptions in their social relationships. These negative social experiences are reflected in the life stories of the affected persons. This study investigates the life stories of patients with personality disorders in order to compare their (positive and negative) perceptions of social experiences before and after a cognitive-behavioral clinical treatment. The purpose of this study is to examine to what extent treatment is related to positive changes in patients' perceptions of their social experiences.

Personality is characterized by individual, different habitual patterns of thinking, feeling and behavior. If personality becomes disturbed or pathological, specific constellations of excessive rigid and/or extreme aspects of the personality become apparent (e.g. antisocial behavior). These dysfunctional constellations can lead to a reduced functioning of the individual in many spheres of daily life, especially in the interpersonal sphere (APA, 2013; Beck & Freeman, 1990).

Personality disorders are often related to problems with self-esteem and conflicts with identity and with poor impulse- and emotion control (Dimaggio et al., 2013). Patients with a personality disorder are especially afflicted with misinterpretations of themselves and of others. These misinterpretations play an important role in the chronic course of personality disorders and are also called "maladaptive interpersonal schemes" (Dimaggio et al., 2013). In this context, Kernberg (2004) emphasizes that the patients' suffering and dysfunctioning in interpersonal relationships is partly determined by these negative ideas, how they represent themselves and how they see others. In this context, sexual- and physical abuse and social neglect in early childhood are known to be important risk factors, which promote the development and progression of maladaptive interpersonal schemes, resp. personality disorders (Emmelkamp & Kamphuis, 2007; Paris, 1997).

The fifth edition of the diagnostic classification system "Diagnostic and Statistical Manual of Mental Disorders (DSM-V)" distinguishes between five criteria that a person has to meet to be diagnosed with a personality disorder, including [1.] the presence of "one or more pathological trait domains or trait facets" and [2.] "impairments in self (identity or self-direction) and interpersonal functioning (empathy or intimacy)". Moreover, [3.] the dysfunctional personality pattern must be stable across time and consistent in different

situations in daily life and [4.] should not be understood as "normative for the individuals' developmental stage or socio-cultural environment". Last but not least, [5.] the pathological personality trait(s) should not be caused by medical conditions (e.g. a severe head trauma) or psychoactive substances (APA, 2013, P. 847-852).

Previous research has shown that psychotherapeutic treatment of patients with personality disorders (e.g. psychodynamic approaches, psychoeducation, cognitive behavioral therapy) is (cost) effective, reduces personality pathology significant and can increase the patients' social functioning and subjective wellbeing (Bartak et al., 2007; Vandereycken et al., 2008; Verheul & Herbrink, 2007). Furthermore, research indicates that the treatment with anxiolytic and antidepressant medication is an appropriate supportive element during and after the psychotherapeutic treatment and significantly reduces psychopathological symptoms (APA, 2013). In this context, Horn (2016) emphasizes that the PD-diagnosis (in most of the mentioned studies ´Borderline´) is an important variable and must be considered when the effectivity of a psychotherapeutic/medical treatment is evaluated.

Despite what is already known about the positive health outcomes of psychotherapeutic treatment by people with a personality disorder, it is still not clear which specific effects psychotherapy has on the patients' mental states and how it leads to psychotherapeutic change in the long term. In this context, qualitative research, like the narrative approach, is an appropriate (complementary) method to evaluate and understand the effectivity and effect mechanisms of psychotherapeutic treatments (Kazdin, 2007).

The idea behind narrative psychology is that people give meaning to their lives by constructing, telling and developing ongoing stories about their various and unique experiences. Through the person's interpretation of these experiences, the reconstructed past, presence and anticipated future are integrated into a "coherent whole", which enables the individual to develop an identity composed of "unity, purpose and meaning" (McAdams & Pals, 2006; Singer, 2004). Two fundamental dimensions of this so called "narrative identity" are communion and agency.

In the broader sense, *communion* means "being part of a larger social or spiritual entity" and refers to the feeling of being (emotional) attached to *others* (Wiggins, 1991). People who are high in communion like to connect with others in warm, close, intimate ways and to care for them. In addition, Abele and Wojciszke (2007) relate communion to qualities like "cooperativeness, [emotional] expressivity, warmth, trustworthiness, interdependence [and] nurturance".

The second dimension is *agency*, which refers to someones view on the *self*. People who score high in agency want to be separate from others (they are highly individualistic "agents"), strive after dominance and power, are conscious of their own skills and strengths and use them to master challenges in daily life (high autonomy and self-efficacy) (Abele et al., 2008). Communion and agency are also called the "Big Two" (Abele & Wojciszke, 2014; Paulus & Trapnell, 2008), because they create the framework in which people perceive/integrate/evaluate their *self* (agency) in the context of *me* and *others* (communion).

Communion can be divided into a positive- and a negative form (Diehl et al., 2004). On the one hand, positive communion means that the individual can give up its own needs/wishes for the general good (team-player, increases others wellbeing, collaborates). Persons can understand the feelings of others and are able to communicate with empathy. On the other hand, communion can also have a negative form, resp. there can be "too much" communion. This is the case, if an individual feels extremely dependent on the opinion/approval of others. Following Diehl et al. (2004), these individuals often have high demands on others and have a vulnerable and instable self-esteem. They are easily devastated if they have the feeling that their "need for communion" is not reciprocated by others. This makes them feel rejected or worthless easily.

Finally, a lack of communal (or: lack of connectedness to other people) often is the result of sexual- and physical abuse and social neglect in the early childhood (Emmelkamp & Kamphuis, 2007; Paris, 1997). In this context, the narrative approach revealed, that the life stories of patients with personality disorders contain significant less communal fulfillment (e.g. statements about positive relationships, feelings of love and attachment, affiliation and solidarity), compared to the life stories of healthy individuals (Adler et al., 2012). Their life stories often contain associations of negative (traumatic) events (e.g. sexual/physical abuse) and devastating/conflictual relationships (Dimaggio et al., 2007).

Research indicates that communion is an essential requirement for optimal wellbeing (Abele & Wojciszke, 2007; Adler, Chin, Kolisetty & Oltmanns, 2012; Helgeson, 1994; Helgeson & Fritz, 2000; McAdams, Hoffman, Mansfield & Day, 1996). It is also known that for individuals with personality disorders, especially with emotionally unstable personality disorder (e.g. Borderline), it is much more difficult to behave "communal" and to create long-lasting and stable relationships with others. One reason is that these patients interpret social interactions often negatively ("maladaptive interpersonal schemes", cognitive level) and that therefore their behavior is much more inappropriate/unstable/uncontrollable in social interactions (behavioral level), compared to healthy individuals (Russell, Moskowitz, Zuroff,

Sookman & Paris, 2007; Robins & Rosenthal, 2011). In this context, the patients' inability to regulate their emotions ("emotional vulnerability", psychological level) makes it for them even harder to build and maintain stable relationships with others (Robins et al., 2011).

The previous studies imply, that increasing the ability to build and maintain stable and constructive relationships with others is an important focus of treatment of patients with personality disorders. In this context, most of the current treatment approaches (CBT, Dialectical Behavior Therapy, Metacognitive Therapy, Emotional Schema Therapy, Acceptance and Commitment Therapy, etc.) integrate and combine multiple components of various approaches (especially from the Mindfulness-Based Cognitive Therapy) and lead in most cases to positive health outcomes and improved social functioning by the affected persons (Baer, 2015; Robins et al., 2011). The "Dialectical Behavior Therapy (DBT)" is currently one of the most effective and intensively studied treatment approach for patients with personality disorders and is mostly applied by (suicidal) patients with Borderline Personality Disorder (BPD). In one meta-analysis, 16 studies, which examined the effectivity of DBT by patients with BPD, were evaluated. The rate of dropout was found to be 27.3% and a moderate effect size was found concerning the reduction of suicidal and self-destructive behavior and personality pathology in general (Kliem, Kröger & Kosfelder, 2010).

The dialectical approach, which integrates and combines cognitive-behavioral-, mindfulness-based- and schema therapy-based elements, is characterized by its behavioral-problem-solving focus and its emphasis on "dialectical processes". Following Linehan (1993), "dialectic" refers to the "necessity of accepting patients, by both themselves and their therapists, as they are within a context of trying to teach themselves to change". This refers to the significance of the patient-therapist relationship, which gives the patient the unique opportunity to learn how to build and maintain a new, but constructive and functional, relationship with someone else, in this case the therapist. In the individual psychotherapy sessions, the patient-therapist relationship represents the various social situations and interactions the patient is confronted with in his or her spheres of daily life. Specific situations, which are difficult for the patient, can be worked through together with the therapist (behavioral level) and thereby the patient gains knowledge and insights about his/her own feelings, behaviors and cognitions and how he/she is perceived by others. During this process, on the one hand, it is important that the therapist tries to acknowledge, *accept* and validate the patient's negative emotions and reflects his or her own feelings. On the other hand, it is important that the therapist creates a "matter-of-fact" attitude, to be able to elaborate and talk with the patient about his or her dysfunctional behaviors (e.g. anti-social

behavior, self-harm). This is important in order to reveal the patients' problematic, resp. dysfunctional response patterns and maladaptive schemes behind them (cognitive level). In the group therapy sessions, the group gives the patient the opportunity, resp. "forum" to integrate the new gained knowledge about his or her behavior/emotions/cognitions to build new relationships and to maintain and intensify existing ties. During this process, the *maladaptive* interpersonal schemes of the patient change and are reframed into *functional* interpersonal schemes (Linehan, 1993). However, not many studies investigated the positive change of the patients' dysfunctional cognitions, concerning social interactions and the theme communion, during a clinical treatment. But, in order to understand the effect mechanism of treatment, it is important to know how treatment changes the patients' cognitions. Therefore, the purpose of this research is to investigate the patients' interpersonal schemes before and after a clinical treatment. It is expected, that these interpersonal schemes positively change during treatment.

This research makes use of the narrative approach to investigate the positive changes in communion during a long-term clinical treatment program for patients with severe personality disorders. This is done by evaluating in which different variants the theme communion is present in the life stories of the patients before and after the treatment. The research questions are: [1.] "How does the theme communion appear in the life stories of the patients?" [2.] "How do communion themes change during treatment?" and [3.] "Does the incidence of communion themes change during treatment?"

This study contributes to fill the knowledge gap of how treatment affects the narrative identity (regarding communion) by patients with personality disorders, which again helps to adapt the treatment to this specific group of patients and finally to improve the (social) wellbeing of patients with personality disorders in the long term.

2. Methods

2.1. Context

This study focus on the investigation of the theme communion in the life stories of patients that participated in the treatment program(s) of Scelta, Apeldoorn, the Netherlands. Scelta is a trans-regional treatment center of the GGZ (Netherlands mental healthcare system) and is specialized in the diagnostic and treatment of patients with personality disorders.

By Scelta, patients are treated with dialectic behavioral therapy and schematic therapy (cognitive-behavioral therapies), group-dynamic group psychotherapy, visual-, music- and

psychomotor therapy and also participate in social reintegration programs. The focus lies on discovering and evaluating the patients' strengths and weaknesses in order to facilitate change (in particular in the functioning in interpersonal relationships). In the treatment-programs, the patients gain knowledge about their cognitions (maladaptive interpersonal schemes), learn how to deal with emotions (recognizing, expressing and accepting negative emotions) and practice difficult social situations in order to gain social skills. Throughout the treatment, the therapists try to build and maintain positive and collaborative relationships with the patients. The ultimate goal is to give the patients more *control* of their lives.

The patients in this study participated in three specific treatment programs, which are summarized below:

- **1. Dialectical-behavioral program:** patients discover their own core beliefs, practice (inter)personal skills and learn how to deal with emotions/crisis; this 10-12 months program is suited for patients with low-level personality problematic;
- **2. Schematic therapy:** patients discover their own patterns of thoughts and behavior, learn to deal with positive and negative aspects of personality (strengths and weaknesses), understand and accept their own identity and situation, and discover coping strategies for emotions; this 10-12 months program is suited for patients with high-level personality problematic;
- **3. Three-days day clinic program:** in this treatment program composed of the dialectical-behavioral approach (Marsha Linehan) and schema therapy (Jeffrey Young), patients learn how to deal with emotions; personality integration and development is the common theme; this 9-11 months program is suited for patients with low/high-level personality problematic

2.2. Participants

All 14 participants of this study have been treated by Scelta with one of the three treatment programs described above. The patients all came from second-line GGZ-departments, where no lasting treatment success could be achieved. All participants are between 18 and 65 years old (mean age: 29.5 years) and, according to the DSM-V, are diagnosed with one or more personality disorder. Patients with the diagnosis "Antisocial personality disorder" were not allowed to participate in the treatment programs and therefore are also excluded from this study. The same applies for patients with an IQ <80. In addition, potential participants with severe emotional vulnerability (problems to regulate emotions,

hypersensitivity etc.) and/or behavioral disorders (no control over own behavior, aggressive, anti-social behavior, etc.) are also excluded.

For a detailed overview of the participants´ characteristics, see table 1. Seven participants (50%) have the diagnosis "Borderline personality disorder" and four (29%) are diagnosed with "Obsessive-compulsive disorder". Most of the participants in this study are female (85%), single, but vary in the level of education.

Table 1: *Participants´ characteristics*

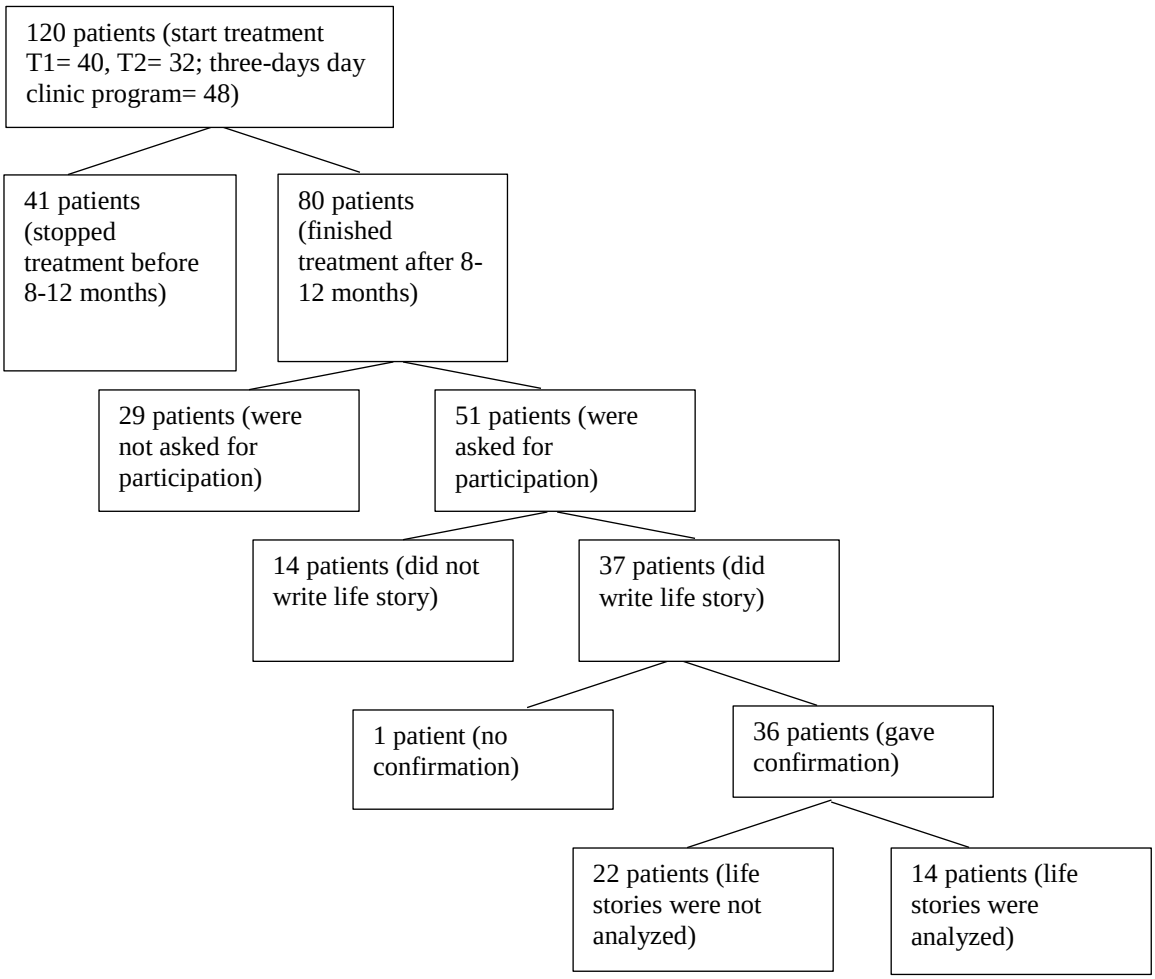
Characteristics	Total (N=14)
Age, mean (SD), years	29.5 (7.9)
Gender	
Female	12
Male	1
No information	1
Diagnosis of Personality disorder	
Borderline PD	7
Avoidant PD	-
Dependent PD	-
Obsessive-Compulsive PD	4
Antisocial PD	-
NAO	3
Education	
Havo	4
Mbo	3
Vmbo	2
Hbo	5
Marital status	
Single	11
Married	3

2.3. Procedure

The patients were referred to Scelta by a general practitioner or another healthcare institution. For their treatment application, the participants had to write down their life story ("For the registration you provide: your life story."). There were no further instructions for the life story. If patients could participate in the program, they were assigned to one of the three treatment programs. The second time the participants were asked to write down their life story was just after their treatment finished ("Please write your life story again."). If they agreed

after their treatment to anonymously participate with their life stories in this study, they were asked to sign the informed consent. For a detailed overview of the recruitment process of the participants, see figure 1. It is worth mentioning that a great number of possible participants (34%) stopped with treatment and therefore could not been considered for this study. Another 27% of the participants, who finished treatment, but did not write the life story(s), were also sorted out.

Figure 1: *Flow chart of participants´ recruitment*



2.4. Qualitative analysis

By means of the software program Atlas.ti (8), the life stories of the participants are analyzed. For the content analysis, a codebook was developed by the researchers, thereby making use of a deductive (top-down) and an inductive (bottom-up) approach.

The deductive analysis was based on the definitions of communion following Diehl et al. (2004) and Abele et al. (2007). Following Diehl et al. (2004), communion refers to a

persons´ feeling of being emotionally *attached* to others. People who score high in communion like the *presence of others* and want to care and connect with them in warm, close, intimate ways. High levels of communion also indicate that the person is motivated to give up its own needs/wishes for the general good, collaborates, wants to increase others wellbeing and responds with *empathy* (Diehl et al., 2004). "Too much" communion refers to a person that feels extremely dependent on the opinion/approval of others. These persons are easily devastated if they have the feeling that they "need for communion" is not reciprocated by others. Abele et al. (2007) emphasize that a lack of communion "manifests itself in, for instance, callousness and repellent behavior."

To be able to evaluate the life stories regarding the theme communion, the researchers (Silvia Pol & Fabian Schug) first of all divided them into meaning units (segments, words and sentences which express one meaningful theme). The content of each meaning unit is evaluated and coded by the researchers regarding the presence and various manifestations of the theme communion. These were derived from the deductive analysis ("presence", "absence" and "too much" communion). During this interactive process between the two researchers, the a priori coding scheme was continuously modified and adjusted until the researchers obtained agreement about the codes. This step was necessary, to assure that the coding scheme can be used as a reliable tool to code the meaning units.

After that, the inductive approach was used to detect relevant, but yet unknown sub codes of the theme communion. Concerning this, no known categories of the theme communion were used to evaluate the life stories. Instead, the meaning units were reduced (condensation) and each meaning unit was then assigned a unique code (abstraction). Unique codes, which were closely related in terms of the content, became sub codes of the theme communion. During the inductive analysis, all relevant (sub) codes, which were already known from the deductive approach, could be recognized. Additionally, the sub code "traumatic experience" was derived from the inductive analysis and added to the codebook. For a detailed overview of all codes, see table 2.

Table 2: *Codebook for Communion*

Theme	Communion		
Main codes	Communion, present	Communion, absent	Communion, too much
Sub codes	- Others present - Attachment - Empathy	- Others absent - Attachment - Traumatic experience	

To ensure that the coding of the life stories is reliable, a training session was conducted. In the training session, dealing with the software program Atlas.ti (8) was practiced. In the training session, me, a fellow student and the extern supervisors (Silvia Pol & Fabian Schug) coded in an interactive atmosphere ("round-table") four life stories and thereby discussed the interpretation of ambiguous meaning units and how to choose for each meaning unit the right code. After the training session, the researchers coded six more life stories independently (336 meaning units in total), in order to assess whether the interrater-reliability (Cohen's kappa) is sufficient. The analysis revealed that the interrater-reliability for the theme communion (including all main and sub codes) is moderate, with k=0.50. Restricted to the three main codes (present, absent and too much communion), the interrater-reliability is considerable, with k=0.70.

2.5. Quantitative analysis

For the quantitative analysis, only data about the three main codes (present, absent and too much communion), was considered. For each of the three main codes, the number of times they were coded in each life story was computed, and then divided by the total number of meaning units in the specific life story. By means of a paired samples t-test, the data (ratio of main codes, %) was compared before and after the intervention.

3. Results

3.1. Qualitative analysis

To answer the first research question **("How does the theme communion appear in the life stories of the patients?"),** the life stories were divided into meaning units and these were coded with the codes "presence", "absence" and "too much" communion.

3.1.1. Presence of communion

Three main themes are strongly related to the presence of communion in the patients' lives. The first indicator is the actual presence of other people. Patients who have (had) contact with other people (family members, friends, lovers, caregivers, etc.), often mention these other people in their life stories. In this context, it is worth mentioning, that those people who were mentioned by the patients, in most cases were people to whom the participants have (had) a close relation (e.g. family members, friends, care givers, etc.).

Quote 1: "I have a two years older sister and a father and mother." (2/2)
Quote 2: "Ones I went to the student psychologist." (7/1)

Except from the actual (only) presence of other people in the patients' lives, the patients' *attachment* to others is the second important indicator for the presence of communion. In its positive form, attachment refers to a person´s sense/perception to be connected to another person/community in a relationship based on trust and mutual acceptance. Many patients report positive experiences with attachment regarding family members and friends.

Quote 3: "Fortunately, I was able to care for her together with my father in the last week of her life." (2/2)
Quote 4: "And I noticed that there are really people who care about me, who I am and what kind of person ever there is in me despite all the disorders!" (6/2)

The last sub-category, which is related to the presence of communion, is empathy (NL: "interspectie"). Empathy refers to the patients' ability to see/feel/understand things from the perspective of others. It is striking that the patients' experiences with empathy are often associated with gaining relevant knowledge and insights. But, not many text segments are labeled with the code "Empathy".

Quote 5: "I was the new girl in the class and therefore many people were interested in me. Thus, every hour someone else wanted to sit next to me. This was totally new to me." (13/1)
Quote 6: "Afterwards, I see how much pain and sleepless nights it caused for them." (30/2)

3.1.2. Absence of communion

The absence of communion refers to a lack of connectedness to other people. In most cases, the participant wished to connect to other people, but, due to circumstances beyond the control of the participant, this was not possible. In the first place, the pure physical absence of others (e.g. after divorce) indicates a lack of communion.

Quote 7: "…but then she immigrated to [non-European country]" (3/1)
Quote 8: "My father was an international truck driver and never at home." (27/1)

A lack of attachment to other people also indicates a lack of communion. In this case, the individual is not able to build or maintain a relationship based on trust and mutual acceptance with others.

> *Quote 9: "The situation at home escalated and he threw me out. After a couple of days [son-in-law] broke off all contact and a few days later my daughter did the same." (2/2)*
> *Quote 10: "As soon as there were feelings (lovingness) there also was anxiety and it went wrong." (4/2)*

Traumatic experiences, which are associated with others (e.g. sexual/physical abuse, bullying), also indicate a lack of communion.

> *Quote 11: "From the first day on at the primary school, I was bullied." (8/2)*
> *Quote 12: "The morning after M. raped me…" (10/2)*

3.1.3. Too much communion

In the case a person only focuses on the wishes and goals of someone else and thereby loses his/her own autonomy, there is talk of too much communion. Often, the affected person wants to captivate someones love/closeness/attention and therefore does everything for the other. Slowly but steadily, the affected person gets dependent - and/or is exploited by the other.

> *Quote 13: "He took more and more space, in my house. Finally, he had seized the whole house, more and more animals were taken home and my own spaces disappeared. I only had a small room in my attic where my sewing machine stood" (2/2)*
> *Quote 14: "…he did it always that way, so that I always forgave him." (2/2)*

3.1.4. The theme communion before and after treatment

The second purpose of this study is to examine how communion themes have changed during treatment **("How do communion themes change during treatment?")**. The results of the qualitative analysis are summarized below.

Presence of communion

The theme communion is present in all life stories before and after treatment. But, when considering the sub codes, differences before and after the treatment of the presence of communion become obvious. First of all, the presence of others is found more often in the life stories before treatment. In the life stories before treatment, the patients often list their family members in a more structured way and mention more friends and relationships they have (had). However, in the second life stories the patients mention more often clinicians/psychologists, in whose treatment they are (were), compared to the life stories before treatment.

"Empathy" is also more present in the life stories before treatment. But, it is striking that experiences with empathy in the second life stories are more often associated with gaining relevant knowledge and insights. For example, in the first life story a patient (w, 24) wrote about her parents in a quite negative way: *"I was afraid of my parents because I lied. They were very angry with me."* In the second life story, the patient also writes about his parents, but in a more "empathic" way: *"I now also see that my father has shown unacceptable behavior. He wanted to protect his daughter at all costs and sometimes he said bad things." (30/2).* Thus, after treatment the patient evaluates the relation with her parents also from the perspective of her father. Thereby, the patient gains a relevant insight concerning her father, that is, that her father loved her and wanted to care for her. Moreover, it seems that the patients' readiness to forgive his or her parents increased during treatment.

Codes concerning the presence of attachment to others are found in the patients' life stories before treatment as often as after treatment. But, it is striking that in the second life stories (after treatment) the relevance of these attachments to others is more related to the here and now, resp. to the current and specific health conditions of the patients. For example: *"Great that there are still people around me who are confident that things will go well with me"* or *"In this year I had a lot of contact with my life counsellor. I find her amazing!" (8/2)*. Thus, it can be concluded that the patients' perspective/perceptions regarding close relations is more optimistic or functional after treatment.

Absence of communion

The absence of communion is also present in all life stories, both, before and after treatment. In the second life stories, the patients mention more often a lack of the pure physical absence of others, compared to the life stories before treatment. Maybe, this is due to the fact, that during the treatment the patients were dealing more intensively with (the consequences of)

their past and therefore recognized more people who have been important to them, but were missing. For example, one patient wrote: *"There was also a teacher, who, as far as I know, forsook me." (7/2)*. This teacher is not mentioned in the patient's life story before treatment.

In both life stories, participants mention situations when they wished to connect to other people (attachment), but, due to circumstances beyond the control of the participants, this was not possible. In contrast with the presence of attachment, it is striking that in the second life stories the relevance of the absence of attachment to others is more referred to the past and not to the current situation (here and now) of the patients. For example: *"In this period I **felt** very abandoned, I **was** on my own." (2/2)*. Then again, in the first life stories (before treatment) patients often report about a lack of attachment they perceive in the here and now, e.g. *"I always **have** the feeling that I am only seen by others when I perform well." (29/1)*. Thus, it can be concluded that after treatment the patients' perspective and perceptions regarding a lack of attachment is more detached and restricted to the past.

Traumatic experiences are found in the patients' life stories before treatment as often as after treatment. This could be due to the fact that traumatic experiences are major life events and therefore for most of the patients omnipresent.

3.2. Quantitative analysis

To analyze whether the incidence of communion themes changed during the treatment **("Does the incidence of communion themes change during treatment?")** three paired samples t-tests were conducted (see table 3). It was analyzed whether the difference in presence, absence and too much communion is significantly different between before and after the treatment. Because the life stories differ enormous in their length, [A] between the patients and [B] before and after the treatment, the ratio of the number of codes (%) was computed. The distribution of the data is normal, therefore using the paired t-test is appropriate.

The paired samples t-tests revealed that the difference for "communion present" before and after the treatment is not significant, with t (14) = -.055, p=.957. Moreover, the difference for "communion absent" before and after the treatment is not significant, with t (14) = -.925, p=.371. The difference between "too much communion before" and "too much communion after" is also not significant, with t (14) = .892, p=.388. Apart from this, the greatest effect size was found for "communion absent" (d = .31), which is according to Cohen (1988) only a small effect. Based on these results, it can be concluded that there were no significant changes during the treatment in the presence of communion, absence of communion and too much

communion in the life stories of the patients. The communion fulfillment of the patients did not change during the treatment.

Table 3: *Presence, absence and too much communion before and after treatment (ratio)*

		M	SD	t	df	Sig. (2-sided, 95%)
Pair 1	Communion present, before	.22	.10	-.055	14	**.957**
	Communion present, after	.23	.10			
Pair 2	Communion absent, before	.10	.05	-.925	14	**.371**
	Communion absent, after	.12	.08			
Pair 3	Too much communion, before	.00	.01	.892	14	**.388**
	Too much communion, after	.00	.00			

4. Discussion and Conclusions

The purpose of this study was to examine in what varieties and quality the theme communion is present in the life stories of patients with a personality disorder and to compare the patients' experiences with communion before and after a cognitive-behavioral clinical treatment. The first research question was: "How does the theme communion appear in the life stories of the patients?" Often the patients mention other people and report experiences, which contain communal elements. Experiences with the presence, absence and "too much" communion can be found in the life stories. The second research question was: "How do communion themes change during treatment?" Striking is that in the second life stories the relevance of positive attachments to others is more related to the here and now, resp. more related to the patients' future and general wellbeing. Moreover, evaluating things from the perspective of others (empathy), seems for many patients to be more important after treatment and in addition is more often related to look back on and reappraise important relations. Beside these qualitative differences, no significant quantitative differences in the theme communion before and after treatment could be found. Therefore, the answer on the third research question ("Does the incidence of communion themes change during treatment?") is "no".

Substantially all participants mentioned other people (sub code: “others presence”). In this context, it is interesting to see, that those people who were mentioned by the patients, in most cases were people to whom the patients have (had) a close relation (e.g. family members, friends, care givers, etc.). This emphasizes the importance of related persons in the lives of patients with a personality disorder. However, it is striking that the patients indeed mention a lot of people in their life stories, but they often do not talk about the *quality* (e.g. depth and length) of the attachments to these people. This phenomenon becomes obvious especially in the life stories before treatment and may be the result of the patients’ inability to maintain stable relationships with others (lack of social skills) (Dimaggio, 2013; Kernberg, 2004). In this context and for future research, investigating the patients’ relations to others in more detail would give new insights into the treatment process/progress. To do so, it is recommended to add a scale to the sub code “attachment present”, which rates the quality of the patient-other relationship (e.g. from one to three).

Furthermore, it is worth mentioning that a large number of positive experiences with communion, which were found in the life stories of healthy people (Abele et al., 2008), were also found in the life stories of patients with a personality disorder. For example, many life stories in this study contain experiences and memories about helping others and being kind, reacting with empathy and seeking for harmony, which refers to the sub codes “attachment” and “empathy”. In this context, previous studies mainly focus on the pathological roots and symptoms of personality disorders and (among other things) emphasize the central role of “maladaptive interpersonal schemes” (Dimaggio, 2013; Emmelkamp & Kamphuis, 2007; Kernberg, 2004). Hence, these studies mainly investigate the dysfunctioning of patients with a personality disorder in social interactions and the differences to healthy people. Consequently, the foremost aim of these traditional studies is to promote the treatment of pathological traits (Sheldon & King, 2001). However, existing studies also imply that [A] general wellbeing, resp. feeling mentally healthy and [B] suffering from psychiatric complaints, are two different things (Slade, 2010; Westerhof & Bohlmeijer, 2010; Lamers, 2012). For example, a person with high-level personality problematic can still have a satisfying degree of wellbeing and, as the current study shows, can make positive experiences in interpersonal relations. This raises the question if we have really understood *to what extent* maladaptive interpersonal schemes impair patients with personality disorders to experience positive social interactions, resp. to reach communion fulfillment. Therefore, paying more attention to the patients’ positive experiences in social relations, strength and general wellbeing is an important message of the study at hand.

Moreover, the researchers were interested to what extent the theme communion changed during treatment in order to draw conclusions about how treatment positively effects the patients' interpersonal (maladaptive) schemes. In this context, the quantitative analysis revealed no significant differences in the various manifestations of the theme communion before and after treatment. However, the qualitative analysis revealed notable differences in the content of the life stories.

First of all, it seems that the patients' capability of empathy (esp. motivation to understand others) and the perspective and perception of attachments to others changed during treatment. That is, that many patients, after treatment, evaluated their relations to others more objective and from the perspective of these others. This finding could be an indication that during treatment the maladaptive interpersonal schemes of the patients changed into more functional cognitions concerning others. It is assumed that the dialectical-based behavior therapy during treatment reinforced the patients' social skills and that patients learned how they are perceived by others. Especially in the group-psychotherapy sessions, the patients were confronted with their own cognitions, feelings and behavior and thereby learned new (behavior) patterns for dealing with themselves and others (Linehan, 1993). That way, changes in the patients' relations to- and perceptions of others took place. These changes are reflected in the patients' life stories after treatment.

Many patients report negative experiences in their life stories, which are often associated with having problems to build and maintain close relationships/intimacy, losing people and especially having worse experiences with other people, such as physical/sexual abuse or having been bullied. However, it is striking that after treatment the patients talk a lot more about their emotions and how they *perceived* traumatic events. Moreover, they interpret and evaluate these events much more from today's perspective, e.g. what helps them to deal with negative experiences and how relations to others support them in the here and now. In this context, previous studies imply that during mindfulness-based treatments (e.g. DBT) patients come into contact with their innermost sensations and learn to deal with them, e.g. by expressing their feelings and thoughts, learn to trust others and accept help (Linehan, 1993; Russell et al, 2007). That way, treatment improves the patients' emotion-regulation, self-acceptance and enables the patients to build and maintain new relationships. As a consequence, the patients stop focusing only on the negative aspects of their disease and draw more attention to the here and now, resp. to the things, which are still helpful and worth living for (e.g. positive relationships) (Russell et al., 2007). These changing perspectives are reflected in the patients' life stories. For future research, it is recommended to investigate the

shifting perspectives of the patients during treatment in more detail. To do so, it is recommended to add the codes “disease perspective: past” and “disease perspective: present/future” to the codebook.

The quantitative analysis revealed no significant increase in the communion fulfillment of the patients during treatment. However, the qualitative differences prove that treatment positively changed the patients’ general attitude and perspectives of social relations and helped the patients to actively develop and maintain positive relationships. Beside this, it is difficult to draw conclusion about the general effect of treatment on patients’ communion fulfillment. One reason is that it must be assumed that the patients wrote their life stories before and after treatment from different perspectives. Before treatment the patients had expectations and had to prepare themselves for their treatment. After treatment they evaluated their treatment and thought ahead. Moreover, during analysis it became obvious that the codebook does not cover all facets of the theme communion (e.g. the depth of attachments). Therefore, not all possible changes in the patients’ experiences of social interactions were analyzed. Patients were also assigned to different treatment programs, which were similar, but had different approaches (schematically and dialectical), which makes it difficult to draw conclusions about the effect mechanisms of treatment.

Unfortunately, the target group of this study was very wide. In other words, there was no distinction made between patients with different personality disorders. Therefore, it is difficult to draw conclusions about how treatment can positively change the interpersonal cognitions of patients with a personality disorder, because the variants of pathological manifestations (maladaptive interpersonal schemes) of different personality disorders is large (Dimaggio, 2013). Therefore, looking at one specific personality disorder makes it easier to understand positive treatment outcomes and changes in interpersonal schemes. In addition, the instructions for writing the life stories were very general. The advantage is that patients are given the freedom to write their life story in the way they want it, which leads to high personal and profound life stories. But, on the other hand, a general instruction also leads to large fluctuations in length and content between the life stories. This makes it harder to compare the theme communion between patients and therefore to draw conclusions about the effects of treatment. Another weak link of this study is the poor interrater reliability. This could be due to the fact that [A] the training session of the researchers, before they coded the life stories, was not intense enough and/or [B] because of the already raised fluctuations between the life stories and/or [C] a lack of necessary codes, which were not considered or found during the deductive and inductive analysis.

Apart from these weak points, this study gives valuable insights into how people with a personality disorder perceive social interactions. A strong point of this study is its authenticity, which is made by the patients self, who wrote very open and authentic descriptions about their (negative) experiences they have made throughout their lives. The researchers were able to gain insights into *how* the patients have experienced their past, what is important for them in the here and now and what ideas and expectations they have for their future. While analyzing the life stories, soon it became clear that the differences between healthy people and those with a personality disorder, concerning the necessity and variety of social interactions, is not as big as often is assumed. Therefore, for future studies it is recommended not only to focus on the patients' pathology and restrictions, but to analyze how we can practically support patients with personality disorders to increase their social wellbeing in the here and now. One way to do so is to draw more attention to the positive and healthy properties of patients with personality disorders. In this context, the effects of the positive psychology on patients' social wellbeing should be investigated in more detail.

To conclude, this study shows that using the narrative approach is an appropriate way to analyze the diverse perspectives, regarding communion themes, of patients with personality disorders and to evaluate how these perspectives change during a cognitive-behavioral clinical treatment. More specific, this study shows that during treatment many patients developed new (constructive) ways to see and deal with existing relationships. Future research should analyze to what extent these changes in the patients perspectives (positively) influence their future relations.

References

Abele, A. E., & Wojciszke, B. (2007). Agency and communion from the perspective of self versus others. *Journal of personality and social psychology*, 93(5), 751.

Abele, A. E., & Wojciszke, B. (2014). Communal and agentic content in social cognition: A perspective model. Advances in experimental social psychology, 50, 195-255.

Adler, J. M., Chin, E. D., Kolisetty, A. P., & Oltmanns, T. F. (2012). The distinguishing characteristics of narrative identity in adults with features of borderline personality disorder: An empirical investigation. *Journal of personality disorders*, *26*(4), 498-512.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders, (DSM-5®)*. American Psychiatric Pub.

Baer, R. A. (Ed.). (2015). Mindfulness-based treatment approaches: Clinician's guide to evidence base and applications. Academic Press.

Beck, A. T., & Freeman, A. (1990). Cognitive Therapy of Personality Disorders. New York: The Guildford Press.

Cohen, J. (1988). Statistical power analysis for the behavioral sciences. Hillsdale, NJ: Lawrence Erlbaum Associates. *Inc, Publishers*.

Diehl, M., Owen, S., & Youngblade, L. (2004). Agency and communion attributes in adults' spontaneous self-representations. *International Journal of Behavioral Development*, *28*(1), 1-15.

Dimaggio, G., Semerari, A., Carcione, A., Nicolō, G., & Procacci, M. (2007). *Psychotherapy of personality disorders: Metacognition, states of mind and interpersonal cycles*. Routledge.

Dimaggio, G., Nicolò, G., Semerari, A., & Carcione, A. (2013). *Investigating the personality disorder psychotherapy process: The roles of smptoms, quality of affects, emotional dysregulation, interpersonal processes, and mentalizing.* Psyhotherapy Research. 23:6, 624-632. doi: 10.1080/10503307.2013.845921

Emmelkamp, P. M. G., & Kamphuis, J. H. (2007). *Personality disorders*. Hove: Psychology Press.

Helgeson, V. S. (1994). Relation of agency and communion to well-being: Evidence and potential explanations. *Psychological bulletin*, *116*(3), 412.

Helgeson, V. S., & Fritz, H. L. (2000). The implications of unmitigated agency and unmitigated communion for domains of problem behavior. *Journal of personality*, *68*(6), 1031-1057.

Horn, E. (2016). *Long-term costs and effects of psychotherapy in personality disorders*.

Kazdin, A. E. (2007). Mediators and mechanisms of change in psychotherapy research. *Annu. Rev. Clin. Psychol.*, *3*, 1-27.

Kernberg, O. F. (2004). Borderline personality disorder and borderline personality organization: Psychopathology and psychotherapy. *Handbook of personality disorders*, 92.

Kliem, S., Kröger, C., & Kosfelder, J. (2010). Dialectical behavior therapy for borderline personality disorder: a meta-analysis using mixed-effects modeling.

Lamers, S.M.A. (2012). *Positive Mental Health. Measurement, relevance and implications*. Enschede: University Press.

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. Guilford press.

Malcolm, W., Warwar, S., & Greenberg, L. (2005). Facilitating forgiveness in individual therapy as an approach to resolving interpersonal injuries. *Handbook of forgiveness*, 379-391.

McAdams, D. P., Hoffman, B. J., Day, R., & Mansfield, E. D. (1996). Themes of agency and communion in significant autobiographical scenes. *Journal of Personality*, *64*(2), 339-377.

McAdams, D. P., & Pals, J. L. (2006). *A new Big Five: fundamental principles for an integrative science of personality*. American Psychologist, 61(3), 204.

Paris, J. (1997). *Childhood trauma as an etiological factor in the personality disorders*. Journal of Personality Disorders. 11(1):34-49.

Robins, C. J., & Rosenthal, M. Z. (2011). Dialectical behavior therapy. *Acceptance and mindfulness in cognitive behavior therapy: Understanding and applying the new therapies*, 164-192.

Russell, J. J., Moskowitz, D. S., Zuroff, D. C., Sookman, D., & Paris, J. (2007). Stability and variability of affective experience and interpersonal behavior in borderline personality disorder. *Journal of Abnormal Psychology, 116*(3), 578.

Sheldon, K. M., & King, L. (2001). Why positive psychology is necessary. *American psychologist, 56*(3), 216.

Singer, J. A. (2004). Narrative identity and meaning making across the adult lifespan: An introduction. *Journal of personality*, 72(3), 437-460.

Slade, M. (2010). Mental illness and well-being: the central importance of positive psychology and recovery approaches. *BMC health services research, 10*(1), 26.

Vandereycken, W., Hoogduin, C. A. L., & Emmelkamp, P .M. G. (2008). *Deel 1 Basisbegrippen. Handboek psychopathologie.* Bohn Stafleu van Loghum. Vierde herziene druk.

Verheul, R., & Herbrink, M. (2007). The efficacy of various modalities of psychotherapy for personality disorders: a systematic review of the evidence and clinical recommendations. *International Review of Psychiatry, 19*(1), 25-38.

Westerhof, G. J., & Bohlmeijer, E. T. (2010). *Psychologie van de levenskunst*. Amsterdam: Boom.

Wiggins, J. S. (1991). *Agency and communion as conceptual coordinates for the understanding and measurement of interpersonal behavior.*

Wojciszke, B., & Abele, A. E. (2008). The primacy of communion over agency and its reversals in evaluations. *European Journal of Social Psychology*, *38*(7), 1139-1147.

Yen, S., Shea, M. T., Battle, C. L., Johnson, D. M., Zlotnick, C., Dolan-Sewell, R. & Zanarini, M. C. (2002). Traumatic exposure and posttraumatic stress disorder in borderline, schizotypal, avoidant, and obsessive-compulsive personality disorders: Fingings from the collaborative longitudinal personality disorders study. *The Journal of nervous and mental disease*, *190*(8), 510-518.

Yu, M., & Clark, M. (2015). Investigating mindfulness, borderline personality traits, and well-being in a nonclinical population. *Psychology*, *6*(10), 1232.