

THE EMPIRICALLY SUPPORTED TREATMENT OF BORDERLINE PERSONALITY DISORDERS

José Guimón and Wendy Dávila

onpquugj@ehu.es

The assessment of efficacy and efficiency of treatment are presently taking on growing importance for the psychiatric practice. For this assessment, scientifically proven therapeutic measures or "Empirically Supported Treatments" are applied using techniques such as randomized controlled trials, the meta-analysis and the "Consumer Reports" studies. The present discussion seeks to evaluate the advantages and disadvantages of these procedures.

1. THE ETIOLOGICAL BASIS FOR CONTEMPORARY THERAPIES

Personality disorders involve un-adapted, invasive, and permanent behaviours, deeply ingrained, and which are not due to any physical illness, nor to cultural alterations. The borderline personality disorder, (BPD), is prevalent, (2% in the general population, 20% among psychiatric in-patients), and has a major impact on health facilities, even if these patients make a poor use of attempts to help them.

The term borderline is inadequate, because it describes, above all, impulsiveness, disordered hostility, self-destructive acts, mood swings, and splitting; i.e., it defines symptoms, not traits. The validity of this concept is thus, not high, because although it has been similarly described in many countries, the biological findings remain doubtful, in spite of some reliable neurophysiological findings.

The patients with BPD have a significantly increased risk of self-destructive and suicidal behaviour (Brodsky et al., 1997), although this risk decreases in the long-term, as there is a decrease in suicidality (Stone, 1993). Some predictors of increased risk for suicidal

behaviour have been detected, mainly impulsivity (Brodsky et al., 1997), comorbid disorders, recent negative life events, a history of childhood sexual abuse (Links, Gould, & Ratnayake, 2003) and neuropsychological disturbances (Krysinska, Heller, & De Leo, 2006).

There has been different aetiological hypotheses proposed to explain this disorder, ranging from constitutional factors, (difficulty in regulating affect), to family and psychodynamic factors: perturbations in the establishment of object relations and inadequate processes of identification during early infancy (Herman, 1992). From an anamnesic viewpoint, in women there seems to be a relationship with childhood abuse and incest. Clarkin & Posner (Clarkin & Posner, 2005) propose a developing model of borderline personality disorder based upon the study of normal attention, individual differences in temperament, self definition and attachment organization. This theoretical construction can relate the symptoms to more enduring temperamental aspects of the patients, with the potential to illuminate the psychology and psychobiology of the disorder and to contribute to psychotherapeutic intervention. The goal, say the authors, will be to “understand the development of neural networks that underlie the abnormalities of adults, and eventually work out the interaction between temperament, genes, and experience, that produce the disorder, and potentially inform intervention”.

Kernberg (Kernberg, 1986; Kernberg, 1980) related personality disorders to early defence mechanisms against sexual and aggressive drives. He referred to a pathological super-ego, an alteration in the ego organisation, a difficulty in internalising object relations, and a pathological development of the narcissistic functions. The author highlighted the role played by the dysfunctions in object relations, established during early infancy. It is in childhood when the patient sets in motion pathological defence mechanisms: systematically using dissociation, acting out, projective identification etc., which will lead to relational difficulties in the adult life. Later studies contend that most core symptoms of the disorder, such as: a diffuse sense of self, bursts of rage, unstable interpersonal relationships, feelings of emptiness and abandonment, chronic fears of, and an intolerance for aloneness, have their roots in an impaired organization of the underlying attachment (in Bowlby's sense). Levy et al (Levy, 2005) underline that individual differences in the attachments of adult people are rooted in the early patterns of interaction with caregivers. These patterns have important implications for

understanding the aetiology and treatment of the borderline personality disorder. The factor analysis of ninety-nine outpatients reliably diagnosed with BPD, and the completion of a number of attachment measures, revealed six factors that clustered into three groups corresponding to: an avoidant attachment pattern, a preoccupied attachment pattern, and a fearfully preoccupied pattern. The preoccupied pattern group showed more concern and behavioural reaction to real or imagined abandonment, whereas the avoidant group had higher ratings of inappropriate anger. The fearfully preoccupied group had higher ratings on identity disturbance, although only at the trend level.

2. THE BIOLOGICAL TREATMENTS

There is no specific treatment for BPD. The treatments based on drugs are only useful in the presence of such symptoms as anxiety or depression, but have no influence on the underlying personality traits. Thus, in cases of anxiety, anxiolytics can be useful, as can antidepressants, if a depression appears. In transitory episodes of borderline disorder, neuroleptics can reduce the anxiety. A combination of drugs, such as: reuptakes of serotonin inhibitors, mood stabilizers and neuroleptics at a low dose level, have been proposed based on some non-controlled studies.

As for hospitalization, it is of unproven value in preventing the suicide of BPD patients, and can sometimes even have negative effects. On the other hand, day treatment is an evidence-based alternative to full admission, but clinicians fear potential litigation resulting from a completed suicide and they end up opting for hospitalization. It is notable, though, that chronic suicidality can be best managed in an outpatient setting (Paris, 2002; Paris, 2004) and is best understood as a way of communicating distress.

Binks et al. (C Binks et al., 2007) review the efficacy of the pharmacological interventions for people with borderline personality, including ten randomised clinical trials, (RCT), comparing any psychoactive drug with any other treatment for people with BPD. It was discovered through two studies comparing antidepressants with placebo that, for ratings of anger, *fluoxetine* may offer some improvement for those in antidepressant therapy over placebo. The small RCT investigating the important outcome of attempted suicide found no difference between *mianserin* and placebo. It was concluded that *haloperidol* may be better

than antidepressants for symptoms of hostility and psychotism. There were few differences between the *monoamine oxidase inhibitors*, (MAOIs) and the placebo, except that people given MAOIs were less hostile in the RCT. The differences between the MAOIs and antipsychotics were also studied, and the results showed no convincing differences. Regarding the RCT's with antipsychotics and placebo, it was found that antipsychotics may affect some mental state symptoms more effectively than placebo, but the results are difficult to interpret clinically and there is little evidence of the advantage of one antipsychotic over another. Finally, in another RCT, it was concluded that *divalproex* (a mood stabiliser) may help the overall mental state, but the data is far from conclusive.

3. THE PSYCHOTHERAPEUTIC APPROACHES

Previously in this paper, we have stated the fact that there exists no specific, all efficient treatment for BPD. In the following section, we aim to highlight those psychotherapeutic approaches that are currently more in use and the conclusions obtained through different relevant studies, concerning the advantages and disadvantages of each treatment, as well as which has proven to give the more efficient results.

The psychotherapy of personality disorders has been evaluated by Perry et al (Perry et al., 1999). They examined the evidence of the effectiveness of fifteen studies, including three randomized, controlled, treatment trials. These studies analyzed different approaches: the psychodynamic/interpersonal, the cognitive-behaviour, the mixed, and the supportive therapies. All studies reported improvement in personality disorders with psychotherapy. They estimated that 25.8% of personality disorder patients recovered, per year, of therapy, a rate sevenfold larger than that in a published model of the natural history of borderline personality disorder.

Bradley & Westen (Bradley & Westen, 2005) describe the psychodynamic conceptions of treatment and the way BPD phenomena manifests itself in treatment. Bender (Bender, 2005) outlines that in BPD, building a good therapeutic alliance is vital in the earliest phase of treatment during which these patients tend systematically to push the limits.

One of these treatments, based on psychodynamic concepts, for BPD is the so called "Transference Focused Psychotherapy", (TFP),(Levy et al., 2006). This individual

psychotherapy involves, at the level of the patient: the integration of polarized representations of self and others, and at the level of the therapist's interventions: the structured treatment approach and the use of clarification, confrontation, and "transference" interpretations, in the "here and now" of the therapeutic relationship. Levy et al. give evidence of the usefulness of the following mechanisms of change: contract setting, integration of representations, and changes in reflective functioning and affect regulation, present in this form of therapy.

Group therapy, along with individual therapy, is a primary tool when treating patients diagnosed of BPD. This therapy is frequently part of a multidimensional programme, including medication and other different types of psychotherapy. The treatment through group work is traditionally used on these patients when they are hospitalised, and it is currently considered of particular interest for out-patients. Springer and Silk (Akrich, 1996; Springer & Silk, 1996) designed an efficient, short programme in this regard. Similarly, Dawson (Agazarian & Janoff, 1993; Dawson, 1988; Dawson & MacMillan, 1993) proposes a programme with the aim of « managing emotions », in which the therapists show themselves as permissive even if they forbid acting out. A controlled study that compared individual and group psychotherapy (Clarkin, Marziali, & Munroe-Blum, 1991; Clarkin, Yeomans, & Kernberg, 1999) showed better results with this second approach.

Nowadays, the therapeutic groups tend to be heterogeneous in composition, although the present most popular programmes (Linnehan's, Kernberg's and Bateman's) are homogeneous. The orientation of groups tends to be eclectic, and although open psychodynamic groups are the most frequent, others (Klein, 1993; Klein & Carroll, 1986) focus on such aspects as acting out, splitting, countertransference, and the focus and eroticisation of relationships.

There is an approach that combines both individual and the group psychotherapy. It is the "Dialectic Behaviour Therapy, or DBT. Significant positive results have been found with this cognitive-behavioural approach created by Linehan. From a theoretical point of view, Linehan made reference to a "dialectic reasoning", which brings into opposition poles such as: emotional vulnerability vs. invalidation, active passiveness vs. competency, and demonstrative crises vs. emotional inhibition. As mentioned, these programs combine individual and group approaches in problem solving and in training in skills. The patients take

part in these groups during at least one year, and then take part in help groups or in groups to reinforce the application of skills. At the individual and concomitant therapy, which also lasts at least one year, the patients are taught to integrate these skills into daily life. The rules to generalize the apprenticeship to the outside world (even with the use of the telephone) are proposed. The group is closed or, at the most, slowly opened.

The DBT has shown efficacy in reducing the suicide rates in the BPD patients (Bateman, 2002; Bateman & Fonagy, 1999) Bateman et al., 1999) (Linehan et al., 2006), (Davidson et al., 2006)

In general, the psychoanalytical approaches are especially based on the theory of object relations. Most of the approaches have been developed in hospital environments or in half-way centers. It is principally the work of Kernberg that uses the psychoanalytical model of object relations (Kernberg, Kibel, Russakoff) in the programme, previously mentioned, of “Transference Focus Psychotherapy”. In this therapy, the importance is placed on increasing the strength of the ego and improving the experience of reality with an attempt at internal reconstitution. From a technical point of view, the splitting mechanism is rather more reinforced than struggled against and an open exteriorization of aggression and the realization of group interpretation based on the « here and now », favouring cohesion, is encouraged.

On their side, Dolan et al. (Dolan, Evans, & Norton, 1995; Dolan, Warren, & Norton, 1997; Dolan, Evans, & Wilson, 1992) in a non-controlled study evaluated the impact of psychotherapeutic treatment in 137 patients hospitalized on the principal symptoms of personality disorder. They noted a significantly greater improvement in those treated than in the group « not admitted » having a significant positive correlation with length of treatment.

And further on, in a naturalistic study, Sabo et al. (Sabo, Gunderson, Navajavits, Chauncey, & Kisiel, 1995) find that suicidal conduct diminished significantly.

More currently, A recent *Cochrane review* (CA Binks et al., 2007) identified seven studies involving 262 people, and five separate comparisons. In the studies comparing dialectical behaviour therapy (DBT), with treatment as usual, no difference was found in the outcome of hospital admissions in the previous 3 months, or in the outcome 6 months after being discharged. One study detected statistical difference in the average scores of suicidal ideation at 6 months, in favour of people receiving DBT, compared with those allocated to

treatment as usual. There was no difference in the outcome of leaving the study early. For the outcome of interviewer-assessed alcohol free days, skewed data have been reported and tend to favour DBT. When a substance abuse focused DBT was compared with comprehensive validation therapy, plus a 12-step substance misuse programme, no clear differences were found for service outcomes or leaving the study early. In similar fashion, when DBT was compared with client centred therapy, no differences were found for service outcomes. However, fewer people in the DBT group displayed indicators of parasuicidal behaviour. There were no differences for outcomes of anxiety and depression, but people who received DBT had less general psychiatric severity than those in the control group. Finally, this one relevant study reports skewed data for suicidal ideation with considerably lower scores for people allocated to DBT. When psychoanalytically oriented partial hospitalization was compared with general psychiatric care, the former tended to come off best. They also observed that people who received treatment in a psychoanalytic orientated day hospital were less likely to be admitted into inpatient care, when measured at different times. In addition, fewer people in psychoanalytically oriented partial hospitalization needed day hospital intervention during the 18 months after discharge. In contrast, more people in the control group took psychotropic medication by the 30 to 36 month follow-up, than those receiving psychoanalytic treatment. The anxiety and depression scores were generally lower in the psychoanalytically oriented partial hospitalization group, as were the global severity scores. The patients receiving psychoanalytic care in a day hospital had better social improvement and social adjustment, using the SAS-SR at 6 to 12 months, than those in general psychiatric cares, though the rates of attrition were the same.

The authors suggest that some of the problems frequently encountered by people with BPD may be amenable to talking/behavioural treatments, but all therapies remain experimental. The studies are too few and too small to inspire full confidence in their results, and the findings must be replicated in larger 'real-world' studies.

These are not controlled studies on the effectiveness of therapeutic community programs, and the multiplicity of variables intervening in the therapeutic process in these settings will make this kind of approaches most unlikely.

Hafner and Holme (Hafner & Holme, 1996) made a prospective study with 48

residents of a therapeutic community with borderline personality disorders. A reduction in significant symptoms took place at discharge after an average stay of 64 days, and the rates of admission to hospital fell in a significant fashion during the year after discharge. Patients rated group therapy as the most useful element of the program.

A training process which corresponds to therapeutic community principles should encourage the growth and differentiation of patients and, as Campling and Haigh (Campling & Dixon Lodge, 1999a, 1999b) warn, avoid indoctrination and infantilization that are typical of medical training but also of psychoanalytical training. Although the philosophy of therapeutic communities has become especially widespread over the last few years in half-way institutions, the hospital-based therapeutic community will continue to justify itself in the treatment of BPD (Schimmel, 1997).

On our side (Guimón, 1998), over the past 20 years we have developed a certain number of group programs, the so called “decaffeinated therapeutic communities” (Guimón, 1999 #2774). These programmes have been developed in many psychiatric services with an orientation towards community therapy in a dozen different care units (short-stay units in general hospitals, day hospitals etc.), both in Spain and in Switzerland (Guimón, 2001a, 2001b; J Guimón, 2002; José Guimón, 2002). They include, at the minimum, a daily medium-sized group bringing together patients and staff and a “small” group of patients, with a dynamic orientation but with occasional cognitive-behavioural tendencies, as well as group activities, (« group work » in Foulkes’ sense).

4. THE USES AND ABUSES OF EVIDENCE BASED PSYCHIATRY

The language of medicine is at once scientific, moral and political. These three languages make up a social body – which has come to be known as the « body of medicine ». Medicine is a “practical”, operational science”. But as Gracia says , it is no longer quite as easy, as it was a few decades ago, to defend the scientific nature of medicine. Admittedly anatomy is a science, just like physiology, biochemistry or microbiology. But none of these sciences strictly identifies with medicine, even if the doctor has to be familiar with all of them to do his job.

Even if psychiatry was one of the first medical specialties to use the tools of evidence-based medicine, these tools, so far, have been applied more often to pharmacological than to

psychological treatments. As we have seen, the conclusions of the last Cochrane review about the efficacy of pharmacological treatments for BPD seem discouraging. The authors conclude that until now, current trials regarding pharmacological treatment of people with BPD are not based on good evidence. However, they suggest that the positive effect of antidepressants in particular, could be considerable. One must keep in mind, though, the fact that “not finding evidence of efficacy of treatment” does not mean that this treatment is ineffective, but that, as the authors of this review used to say: “further well designed, conducted, and reported clinically meaningful trials are needed”. Unfortunately, there still not a controlled study on the efficacy of the combined use of Impulsivity Rating Scales, (IRSS), humour stabilizing drugs, and low dosages of antipsychotics. The example of the beneficial use of medication “cocktails” in the treatment of AIDS should be encouraging the evaluation of these combinations in BPD. In this challenging domain of the efficacy of psychotherapy, some Cochrane collaboration systematic reviews and other reviews, (i.e. the Patient Outcomes Research Team programme in Baltimore), have appeared during the last years (Thorncroft & Szmukler, 2001). This growing interest has led to the formation of task forces to: define, identify, and disseminate information about empirically supported psychological interventions (Barlow, Levitt, & Bufka, 1999; Chambless & Hollon, 1998; Sanderson, 1998). The American Psychological Association Task Force on the Promotion and Dissemination of Psychological Procedures, proposes some characteristics of empirically supported psychotherapy treatments (O'Donohue, Buchanan, & JE, 2000). They include skill building, have a specific problem focus, incorporate continuous assessment of client progress, and involve brief treatment contact, requiring 20 or fewer sessions. To be “well-established”, the treatments for specific disorders must be shown to be efficient in at least two independent RCTs. However, the task force recognizes that these findings are in part an artefact of sociological factors present in contemporary psychotherapy

Many psychiatrists have reservations about the “evidence-based” approach because of perceived limitations in methodology (Mundt & Backenstrass, 2001), gaps in interpreting the available evidence, and neglect of the individual patient uniqueness in quantitative research through annualised treatment procedures (Beutler, 2000).

Concerning BPD, the settings of the psychotherapy RCTs are highly artificial. The

naturalistic studies should be complemented, and efficiency studies in whole health care systems should be done, if they pretend to be relevant to practice. Finally, empirically supported BPD psychological treatments (Linnehan's and Bateman's) have not been effectively disseminated among the mental health professionals who deliver therapy around the world, and thus, are not readily available to the public who require them (Barlow et al., 1999) (Goldfried, TD, Clarkin, Johnson, & Parry, 1999).

The therapists complain that therapy research on BPD has only a remote resemblance to what goes on in actual clinical practice. There is a need of training of staff to implement new psychological treatments, addressing professional barriers that may limit the uptake, and of leading investigations that study the 'minimum effective dose' or the key active ingredients of the interventions.

To overcome these difficulties, some authors propose to make more naturalistic studies, and others plead to add criteria deriving from mental health policy and economics (Buchkremer & Klingberg, 2001). In this sense, Barlow (Barlow et al., 1999) offers a way to overcome the problems of rigid manuals, as well as those associated with forcing clinicians to adhere to theories and practices that are outside of their interest, experience, and expertise.

New models of research have also been proposed. Margison (Margison et al., 2000) supports a model of professional self-management 'practice-based evidence', as a complementary paradigm to improve clinical effectiveness in routine practice via the infrastructure of "Practice Research Networks". For the prediction of responses to the course of treatment, Lutz et al (Lutz, Lowry, Kopta, Einstein, & Howard, 2001) combine a dose-response model with growth curve modelling, to determine dose-response relations for well-being, symptoms, and functioning. Barkham, (Barkham et al., 2001) argues for a core outcome measure, (the "Clinical Outcomes in Routine Evaluation-Outcome Measure"), to provide practice-based evidence for the psychological therapies to complement the existing evidence-based practice paradigm. Kendall et al. (Kendall, Marrs-Garcia, Nath, & Sheldrick, 1999) propose "normative comparisons", a procedure for evaluating the clinical significance of therapeutic interventions, consisting of comparing data on treated individuals with that of normative individuals. Mundt and Backenstrass emphasize the importance of a more detailed psychopathology, (through data that can be expected from neurosciences), which can then be

matched to specific psychotherapy tools (Mundt, 2001).

SUMMARY

Evidence-based pharmacological and psychotherapeutic interventions have claimed positive results in several randomized controlled studies of BPD. However, two recent meta-analytical Cochrane reviews consider that there is not yet “good evidence” of their efficacy, and that further controlled studies are possible and needed. The authors of the present paper remind that “not finding evidence of efficacy of treatment” does not mean that the treatment is ineffective, but as those who made this kind of meta-analytic enquiries say “further well designed, conducted and reported clinically meaningful trials are needed”.

The authors underline the usefulness of the “evidence-based” movement that has appeared in medicine and in psychiatry, as a regulative idea and a research method. It is, also, a powerful socio-political endeavour; and, it entails important ethical implications, since moral neutrality is a myth when referring to the incompatible ethical positions inherent in clinical and research practices..

RESUMEN

Los pacientes con TLP tienen un riesgo significativamente mayor de conductas autodestructivas y suicidas, aunque este riesgo disminuye a largo plazo, al haber una disminución de los comportamientos autoagresivos y se ha descubierto que ambos pueden disminuir, si se tratan de forma efectiva en los años de juventud. Por ello, en la evaluación de pacientes con TLP es muy importante incluir la detección de predictores de un riesgo elevado de conducta suicida.

No hay un tratamiento específico para el TLP. El tratamiento farmacológico es útil únicamente frente a síntomas, tales como la ansiedad o depresión, pero no tienen influencia alguna en los rasgos de personalidad subyacentes. El valor de la hospitalización a la hora de prevenir el suicidio en pacientes con TLP, no está probado, y a veces, incluso puede tener efectos negativos. Por otro lado, el tratamiento en unidades de día es una alternativa a la hospitalización, pero los clínicos temen un posible litigio, debido al temor a que el paciente se suicide y acaban optando por la hospitalización.

Una Revisión Cochrane de Binks et al. en 2007 concluye a través de dos estudios que comparaban los antidepresivos con el placebo que, para el índice de ira, la *fluoxetina* puede provocar alguna mejora respecto al grupo placebo y que el *haloperidol* podía ser más efectivo que los antidepresivos para síntomas de hostilidad y psicoticismo. No existían diferencias entre los *inhibidores de monoamino oxidasa*, (IMAO), y el placebo, excepto que las personas a las que se les administraron IMAOs se mostraban menos hostiles. Los antipsicóticos pueden afectar algunos estados mentales sintomáticos de forma más efectiva que el placebo, pero los resultados son difíciles de interpretar clínicamente y hay poca evidencia de la ventajas de un antipsicótico sobre otro. Finalmente, en otro estudio controlado se concluyó que el *divalproex*, (un estabilizador del humor), puede ayudar al estado mental general, pero los datos están lejos de ser concluyentes.

La psicoterapia de los trastornos de la personalidad fue revisada por Perry et al. en quince estudios, incluidos tres estudios controlados. Estos estudios analizaban diferentes abordajes: el psicodinámico/interpersonal, el cognitivo-conductual, el mixto y las terapias de apoyo. Todos los estudios informaron de una mejora en los trastornos de personalidad tras la psicoterapia. Estimaron que el 25% de los pacientes con trastornos de personalidad se recuperaban, cifra siete veces mayor que en un modelo publicado sobre el transcurso natural del trastorno límite de la personalidad.

Uno de estos tratamientos, basado en la concepción dinámica, para los TLP, es la llamada “Psicoterapia focalizada en la transferencia”, (TFP) propuesta por el grupo de Kernberg y Levy.

La terapia de grupo, junto con la terapia individual, es una herramienta clave en el tratamiento de los TLP. Esta terapia es frecuentemente parte de un programa multidimensional, incluyendo la medicación y otras formas de tratamiento. Los grupos terapéuticos tienden a ser heterogéneos en su composición, aunque los programas más populares en la actualidad, (los de Linehan, Kernberg y Bateman), son homogéneos. La orientación de los grupos tiende a ser ecléctica, y aunque los grupos psicodinámicos abiertos son los más frecuentes.

Se han hallado resultados positivos significativos con la terapia cognitivo-comportamental de Linehan que combina abordajes grupales e individuales en la resolución de problemas y en el entrenamiento en habilidades. Esta terapia “dialéctica comportamental”,

ha mostrado ser eficaz para la disminución de los índices de suicidio en pacientes con TLP, como demuestra un estudio controlado de Linehan en 2006), que comparaba la TDC y el tratamiento comunitario por expertos.

En general, los abordajes psicoanalíticos están basados en la teoría de las relaciones objetales. Los trabajos recientes de Bateman y Fonagy muestran resultados favorables con un tratamiento basado en una psicoterapia dinámica (con una técnica que denominan “mentalización”) en un hospital de día. Los comportamientos automutiladores y los intentos de suicidio decrecieron durante los 18 meses de programa y también disminuyó la estancia hospitalaria media en contraste con aquellos que habían seguido un tratamiento general.

Una *revision Cochrane* reciente de Blinks y cols en 2007 identifica siete estudios que implican a 262 personas, y con 5 comparaciones distintas. Los autores sugieren que algunos de los problemas con los que usualmente se enfrentan las personas con un trastorno límite de la personalidad pueden ser susceptibles de tratamientos verbales/comportamentales. Sin embargo, todas las terapias continúan siendo de carácter experimental, y los estudios son demasiado escasos y reducidos para suscitar una plena confianza en sus resultados. Estos hallazgos requieren replicarse en estudios mayores más semejantes al “mundo real”.

No existen estudios controlados acerca de la efectividad de los programas de las Comunidades Terapéuticas, y la multiplicidad de variables que intervienen en el proceso terapéutico en estos ambientes hace que este tipo de abordaje sea poco probable. Existen algunos estudios “naturalísticos” que muestran la eficacia, entre ellos, unos realizado en Bilbao en que se muestra la eficacia de un programa de día de 50 días, de media de duración de cuatro horas semanales.

REFERENCES

- Agazarian, Y. M., & Janoff, S. (1993). Systems theories and small groups. In W. Wilkins (Ed.), *Comprehensive Group Psychotherapy* (pp. 32-44). Baltimore.
- Akrich, M. (1996). Le médicament comme objet technique. *Revue Internationale de Psychopathologie*, 21, 135-158.
- Barkham, M., Margison, F., Leach, C., Lucock, M., Mellor-Clark, J., Evans, C., Benson, L., Connell, J., Audin, K., & McGrath, G. (2001). Service profiling and outcomes benchmarking using the CORE-OM: toward practice-based evidence in the psychological therapies. *Clinical Outcomes in Routine Evaluation-Outcome Measures*.

- J Consult Clin Psychol, 69(2), 184-196.
- Barlow, D., Levitt, J., & Bufka, L. (1999). The dissemination of empirically supported treatments: a view to the future. *Behav Res Ther*, 37(Suppl 1), 147-162.
- Bateman, A. (2002). Integrative therapy from an analytic perspective. In A. Bateman (Ed.), *Integration in Psychotherapy. Models and Methods*. (pp. 11-27). New York: Oxford University Press.
- Bateman, A., & Fonagy, P. (1999). Effectiveness of partial hospitalization in the treatment of borderline personality disorder: a randomized controlled trial. *Am J Psychiatry*, 156(10), 1563-1569.
- Bender, D. (2005). The therapeutic alliance in the treatment of personality disorders. *Psychiatr Pract.*, 11(2.), 73-87.
- Beutler, L. (2000). David and Goliath. When empirical and clinical standards of practice meet. *Am Psychol*, 55(9), 997-1007.
- Binks, C., Fenton, M., McCarthy, L., Lee, T., Adams, C., & Duggan, C. (2007). Pharmacological interventions for people with borderline personality disorder. *Cochrane Database of Systematic Reviews*(1).
- Binks, C., Fenton, M., McCarthy, L., Lee, T., Adams, C., & Duggan, C. (2007). Psychological therapies for people with borderline personality disorder. *Cochrane Database of Systematic Reviews*(1).
- Bradley, R., & Westen, D. (2005). The psychodynamics of borderline personality disorder: a view from developmental psychopathology. *Dev Psychopathol.*, 17(4), 927-957.
- Brodsky, B., Malone, K., Ellis, S., Dulit, R., & Mann, J. (1997). Characteristics of borderline personality disorder associated with suicidal behavior. *Am J Psychiatry.*, 154(12), 1715-1719.
- Buchkremer, G., & Klingberg, S. (2001). What is science-based psychotherapy? On the discussion of guidelines for psychotherapy research. *Nervenarzt*, 72(1), 20-30.
- Campling, P., & Dixon Lodge, F. (1999a). Boundaries: Discussion of a Difficult Transition. In R. Haigh (Ed.), *Therapeutic Communities. Past, Present and Future*. London: Jessica Kingsley Publishers.
- Campling, P., & Dixon Lodge, F. (1999b). Chaotic personalities: Maintaining the Therapeutic Alliance. In R. Haigh (Ed.), *Therapeutic Communities. Past, Present and Future*. London Jessica Kingsley Publishers.
- Chambless, D. L., & Hollon, S.-D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology*, 66(1), 7-18.
- Clarkin, J., & Posner, M. (2005). Defining the mechanisms of borderline personality disorder. *Psychopathology*, 38(2), 56-63.
- Clarkin, J. F., Marziali, E., & Munroe-Blum, H. (1991). Group and family treatments for borderline personality disorder. *Hospital Community Psychiatry*, 42, 1038-1043.
- Clarkin, J. F., Yeomans, F. E., & Kernberg, O. F. (1999). *Personality for bordeline personality*. New York: Wiley.
- Davidson, K., Norrie, J., Tyrer, P., Gumley, A., Tata, P., Murray, H., & Palmer, S. (2006). The effectiveness of cognitive behavior therapy for borderline personality

- disorder: results from the borderline personality disorder study of cognitive therapy (BOSCOT) trial. *J Personal Disord.*, 20(5), 450-465.
- Dawson, D. F. (1988). Treatment of the borderline patient, relationship management. *Can J Psychiatry*, 33(5), 370-374.
- Dawson, D. F., & MacMillan, H. L. (1993). *Relationship Management of the Borderline Patient*. New York: Brunner/Mazel.
- Dolan, B., Evans, C., & Norton, K. (1995). Multiple axis-II diagnoses of personality disorder. *British Journal of Psychiatry*, 166(1), 107-112.
- Dolan, B., Warren, F., & Norton, K. (1997). Change in borderline symptoms one year after therapeutic community treatment for severe personality disorder. *British Journal of Psychiatry*, 171, 274-279.
- Dolan, B. M., Evans, C., & Wilson, J. (1992). Therapeutic community treatment for personality disordered adults: changes in neurotic symptomatology on follow-up. *International Journal of Social Psychiatry*, 38(4), 243-250.
- Goldfried, M., TD, B., Clarkin, J., Johnson, L., & Parry, G. (1999). Toward the development of a clinically useful approach to psychotherapy research. *J Clin Psychol*, 55(11), 1385-1405.
- Guimón, J. (1998). *Thérapie groupale dynamique intensive et brève*. *Psychothérapies*, 18(1), 15-21.
- Guimón, J. (2001a). *Intervenciones en Psiquiatría comunitaria (Vol. 3)*. Madrid: Core Academic.
- Guimón, J. (2001b). *Introduction aux thérapies de groupe*. Paris: Masson.
- Guimón, J. (2002). Groups in Therapeutic Communities. In J. J. Magnavita (Ed.), *Comprehensive Handbook of Psychotherapy (Vol. 1, pp. 529-549)*. New York: John Wiley & Sons, Inc.
- Guimón, J. (2002). Psychodynamic/Object-Relations group Therapy with Schizophrenic Patients. In J. J. Magnavita (Ed.), *Comprehensive Handbook of Psychotherapy (Vol. 1, pp. 481-501)*. New York: John Wiley & Sons, Inc.
- Hafner, R. J., & Holme, G. (1996). The influence of a therapeutic community on psychiatric disorder. *Journal of Clinical Psychology*, 52(4), 461-468.
- Herman, J. (1992). *Trauma and Recovery*. New York: Basic Books.
- Kendall, P., Marrs-Garcia, A., Nath, S., & Sheldrick, R. (1999). Normative comparisons for the evaluation of clinical significance. *J Consult Clin Psychol*, 67(3), 285-299.
- Kernberg, O. (1986). *Internal world and external reality. Object relations theory applied*. New York: Jason Aronson.
- Kernberg, O. F. (1980). Neurosis, psychoses and the borderline states. In J. Sadock (Ed.), *Comprehensive Textbook of Psychiatry*. Baltimore: Williams & Wilkins.
- Klein, R. H. (1993). Short-term group psychotherapy. In W. Wilkins (Ed.), *Comprehensive Group Psychotherapy (pp. 256-270)*. Baltimore: Williams & Wilkins.
- Klein, R. H., & Carroll, R. A. (1986). Patient characteristics and attendance patterns in outpatient group psychotherapy. *International Journal of Psychotherapy*, 35, 115-132.
- Krysinska, K., Heller, T., & De Leo, D. (2006). Suicide and deliberate self-harm in personality disorders. *Curr Opin Psychiatry*, 19(1), 95-101.
- Levy, K. (2005). The implications of attachment theory and research for

- understanding borderline personality disorder. *Dev Psychopathol*, 17(4), 959-986.
- Levy, K., Clarkin, J., Yeomans, F., Scott, L., Wasserman, R., & Kernberg, O. (2006). The mechanisms of change in the treatment of borderline personality disorder with transference focused psychotherapy. *J Clin Psychol*, 62(4), 481-501.
- Linehan, M., Comtois, K., Murray, A., Brown, M., Gallop, R., Heard, H., Korslund, K., Tutek, D., Reynolds, S., & Lindenboim, N. (2006). Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder. *Arch Gen Psychiatry*, 63(7.), 757-766.
- Links, P., Gould, B., & Ratnayake, R. (2003). Assessing suicidal youth with antisocial, borderline, or narcissistic personality disorder. *Can J Psychiatry*., 48(5), 301-310.
- Lutz, W., Lowry, J., Kopta, S., Einstein, D., & Howard, K. (2001). Prediction of dose-response relations based on patient characteristics. *J Clin Psychol*, 57(7), 889-900.
- Margison, F., Barkham, M., Evans, C., McGrath, G., Clark, J., Audin, K., & Connell, J. (2000). Measurement and psychotherapy. Evidence-based practice and practice-based evidence. *Br J Psychiatry Aug*, 177, 123-130.
- Mundt, C., & Backenstrass, M. (2001). Prospects in psychotherapy research (article in German). *Nervenarzt*, 72(1), 11-19.
- Myerson, A. (1994). The attitude of neurologists, psychiatrists and psychologists towards psychoanalysis (1939). *Am J Psychiatry*, 151(6), 48-54.
- O'Donohue, W., Buchanan, J., & JE, F. (2000). Characteristics of empirically supported treatments. *J Psychother Pract Res*, 9(2), 69-74.
- Paris, J. (2002). Chronic suicidality among patients with borderline personality disorder. *Psychiatr Serv.*, 53(6), 738-742.
- Paris, J. (2004). Is hospitalization useful for suicidal patients with borderline personality disorder? *J Personal Disord.*, 18(3), 240-247.
- Sabo, A. N., Gunderson, J. G., Navajavits, L. M., Chauncey, D., & Kisiel, C. (1995). Changes in self-destructiveness of borderline patients in psychotherapy. A prospective follow-up. *Journal of Nervous and Mental Disease*, 183(6), 370-376.
- Sanderson, W. (1998). The case for evidence-based psychotherapy treatment guidelines. *Am J Psychother*, 52(3), 382-387.
- Schimmel, P. (1997). Swimming against the tide? A review of the therapeutic community. *Australian and New Zealand Journal of Psychiatry*, 31(1), 120-127.
- Springer, T., & Silk, K. R. (1996). A review of inpatient group therapy for borderline personality disorder. *Harvey Review of Psychiatry*, 3(5), 268-278.
- Stone, M. (1993). Paradoxes in the management of suicidality in borderline patients. *Am J Psychother.*, 47(2), 255-272.
- Thornicroft, G., & Szmukler, G. (Eds.). (2001). *Textbook of Community Psychiatry*. New York: Oxford University Press.