

FROM THE COACH TO THE COMMUNITY?

PSYCHOTHERAPEUTIC TREATMENT OF BORDERLINE DISORDERS

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SUMMARY

Patients with Borderline Personality Disorder are difficult to manage in individual analytical psychotherapy, due to their instability, which is frequently related to a loss of self-esteem and identity confusion. Group therapy, traditionally used in these patients when they are hospitalised, is currently considered of particular interest for out-patients. Group therapy is frequently part of a multidimensional programme, including medication and different types of psychotherapy. Therapeutic communities has become especially widespread over the last few years in half-way institutions for Borderline personality disorders. The hospital-based therapeutic community combines socio-therapeutic treatment, psychotherapeutic treatment and the advantages of a hospital context and it has shown itself to be useful in the treatment of borderline personality disorder

KEY WORDS

Therapeutic Communities; group psychotherapy; Borderline Personality Disorder

Personality disorders involve inadaptive, invasive, and permanent behaviours, deeply engrained, and which are not due to any physical illness, nor to cultural alterations. Borderline personality disorder is prevalent (2% in the general population, 20% among psychiatry 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 are doubtful, in spite of some reliable neurophysiological findings.

Different aetiological hypotheses have been 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. A developing model of borderline personality disorder based upon the study of normal attention, individual differences in temperament, self definition and attachment organization, can relate the symptoms to more enduring temperamental aspects of the patients. (Clarkin & Posner, 2005) 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”.

These patients are difficult to manage in individual analytical psychotherapy, due to their instability, which is frequently related to a loss of self-esteem and identity confusion. The course of therapy tends to be disturbed by intense transferences and various acts, such as suicide attempts, attacks of rage, and self-mutilation caused by suicidal thoughts. Kernberg (Alexander, 1968; Kernberg, 1968) recommended confronting these patients and interpreting their negative transference early on, whereas other authors (Buie & Adler, 1982) advise therapists to limit themselves to acting as a holding environment for the patient and avoid interpretations. There is a high percentage of drop-out in these patients.

1.2. Group Therapy

Group therapy, traditionally used in these patients when they are hospitalised, is currently considered of particular interest for out-patients. Springer and Silk (Akrich, 1996; Springer & Silk, 1996) designed an efficient, short programme, and discussed, particularly, the advantages and disadvantages of Linehan's dialectical behaviour therapy (Abrahms &

. Indeed, group therapy offers the advantages of being less expensive; making transference easier to manage; and producing an improvement in ego functioning (Kretsch, Goren, & Wasserman, 1987) and interpersonal functioning (Schreter, 1970, 1978)(Schreter, 1970, 1978), and a drop in the patient's regressive tendencies (Horowitz, S.C., & Howell-White, 1996; Horowitz, 1987). Moreover, these patients are more likely to take advice or have confrontations with other patients than with the therapist, and they have the possibility to relate with them on an equal level.

Dawson (Agazarian & Janoff, 1993; Dawson, 1988; Dawson & MacMillan, 1993) proposes a program with the aim of « managing emotions » in which therapists show themselves as permissive even if they forbid acting out. Regular attendance at meetings is not obligatory, which means that only 30% of regular presence which forms the nucleus of patients is more or less constant, while there exists in addition a much greater cloud of patients who show up from time to time in the group searching for occasional help

1.3. Multidimensional programmes

Group therapy is frequently part of a multidimensional programme, including medication and different types of psychotherapy.

Some fairly specific treatments have been used, including serotonin reuptake inhibitors, mood stabilisers, and neuroleptics at a low dose level.

The therapeutic groups tend to be heterogenous in composition although the present most popular programs (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.

1.4. Part time or full time Hospitalisation

Because of these risks of acting out, the therapist must be able to count on a support system offering more holding for these kinds of patients, i.e. a hospital unit (which should be avoided as much as possible in order to not embark on a prolonged and counterproductive relationship with the institution) or a day hospital.

With a dynamic perspective recent work by Bateman and Recent work by Bateman

and Fonagy (Bateman, 2002; Bateman & Fonagy, 1999)(Bateman et al., 1999) has shown favorable results with treatment based on dynamic psychotherapy in a day hospital.

Springer k (Springer & Silk, 1996)(Springer & Silk, 1996) , based on existing literature, proposes a framework in which an effective, short-term group treatment is organized and they discuss, in particular, the advantages and disadvantages of the adaptation of Linehan's Dialectical Behavior Therapy by using it short term for hospitalized patients.

On their side, Dolan et al. (Dolan, Evans, & Norton, 1995; Dolan, Warren, & Norton, 1997; Dolan, Evans, & Wilson, 1992)(Dolan, Warren, & Norton, 1997) 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 » in a significant positive correlation with length of treatment. Similarly, Hafner and Holme (Hafner & Holme, 1996)(Hafner & Holme, 1996) made a prospective study with 48 residents of a therapeutic community with borderline personality disorders

1.5. Therapeutic communities.

. However, this type of approach should be an antidote to the trend toward managed care. Effectively, some borderline patients with serious symptoms (incompetence, suicidality, dependency) who suffer from a feeling of profound insecurity will continue to need long-term, intensive therapy and we should display some reticence when faced with attempts to reduce or dilute the services we offer(Camplung & Dixon Lodge, 1999a, 1999b)(Camplung & Dixon Lodge, 1999a, 1999b; Camplung & Haigh, 1999). A training process which corresponds to therapeutic community principles should encourage the growth and differentiation of patients and, as Camplung and Haigh warn, avoid indoctrination and infantilization that are typical of medical training but also of psychoanalytical training As we already pointed out, 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. Effectively, it combines socio-therapeutic treatment, psychotherapeutic treatment and the advantages of a hospital context (Schimmel, 1997); it has shown itself, moreover, to be useful in the treatment of borderline personality disorder and the rehabilitation of certain delinquents.

On our side (Guimón, 1998), over the past 20 years we have developed a certain

number of group programs (“decaffeinated therapeutic communities” (Guimón, 1999 #2774)(Guimón 1999) in many psychiatric units with an orientation towards community therapy in a dozen different care units (short-stay units in general hospitals, rehabilitation units, day hospitals) in Spain and in Switzerland (Guimón, 2001a, 2001b; J Guimón, 2002; José Guimón, 2002)(Guimón, 2001). The programs of these units 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-behavioral tendencies as well as group activities (« group work » in Foulkes’ sense).

2. RESULTS

The assessment of efficacy and efficiency of treatment are presently taking on growing importance for psychiatric practice . . . Scientifically proven therapeutic measures or "Empirically Supported Treatments" are proposed through techniques such as randomized controlled trials, the meta-analysis

Group therapy was found to be as efficient as individual therapy in the above mentioned program of « managing emotions » (Dawson, 1988 1993) and patients who participated in groups showed better treatment compliance.

. A controlled study compared individual and group psychotherapy (Clarkin, Marziali, & Munroe-Blum, 1991; Clarkin, Yeomans, & Kernberg, 1999)(Clarkin, Marziali, and Munroe-Blum, 1991) showed better results with this approach.

Sabo et al. (Sabo, Gunderson, Navajavits, Chauncey, & Kisiel, 1995)(Sabo et al., 1995) followed up, in a prospective fashion, 37 hospitalized patients suffering from borderline personality disorder over a five-year period to evaluate the changes in two forms of self-destructiveness. They noted that suicidal conduct diminished significantly, that self-aggressive conduct presented a certain tendency but not a significant decrease and that aggressive ideation (both suicidal and self-destructive) did not decrease in a notable fashion.

Significant positive results have been found with the cognitive-behavioral approach of Linehan. This method had been initiated for young women who were parasuicidal and was then extended to persons with behavioral problems to resolve « dialectic » failures. Effectively, from a theoretical point of view, Linehan made reference to this dialectic

reasoning which brings into opposition poles such as emotional vulnerability vs. invalidation, active passiveness vs. competency, demonstrative crises vs. emotional inhibition.

These programs combine individual and group approaches in problem solving and in training in skills. In the psychoeducational groups, patients are taught a certain number of skills in regulating emotion, inter-personal functioning and stress tolerance. Patients take part in these groups during at least one year, then take part in help groups or to reinforce the application of skills. In individual and concomitant therapy, which lasts at least one year, we teach patients to integrate these skills into daily life. 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 maximum, slowly opened.

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 who uses the psychoanalytical model of object relations (Kernberg, Kibel, Russakoff) in their program "Transference Focus Psychotherapy". The accent is placed on increasing the fortress of the ego and improving the experience of realities with an attempt at internal reconstitution. From a technical point of view, the splitting mechanism is rather reinforced than struggled against and we propose open exteriorizing of aggression and the realization of group interpretation based on the « here and now » which favors cohesion.

Bateman and Fonagy These authors compared the evolution of 19 patients who were treated through in hospitalization which was partially oriented from a psychoanalytical point of view compared with the same number of patients who had received a general psychiatric treatment. Self-mutilating behavior and suicide attempts decreased during the 18-month program. In the same way, the average hospital stay was shortly than for those who followed specific treatment.

Wood et al.(Wood, Trainor, Rothwell, Moore, & Harrington, 2001)(Wood et al., 2001) compared group therapy with routine care in adolescents (most of them borderline)who had deliberately harmed themselves and find o had that group therapy were less likely to be "repeaters" although did not differ, however, in their global outcome. Hawton et al (Hawton et al., 2002)(Hawton et al., 2002) evaluated all randomised controlled trials regarding the effectiveness of treatments of patients who have deliberately self-harmed and find reduced

rates of further self-harm for depot flupenthixol vs. placebo and for dialectical behaviour therapy vs. standard aftercare.

Hafner and Holme (Hafner & Holme, 1996) in order to determine which elements of the program were most useful. A reduction in significant symptoms on the Brief Symptom Inventory 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 study by Sabo et al. (Sabo, Gunderson, Navajavits, Chauncey, & Kisiel, 1995) follows in a prospective fashion 37 patients hospitalized suffering from borderline personality disorder during five years to evaluate the changes in two forms of self-destructiveness. Finally, Schimmel (Schimmel, 1997) underlines the efficacy of therapeutic community treatment for patients suffering from borderline personality disorder.

A recent *Cochrane review* (Binks et al., 2007) identified seven studies involving 262 people, and five separate comparisons. Comparing dialectical behaviour therapy (DBT) with treatment as usual studies found no difference for the outcome by six months or admission to hospital in previous three months. Self harm or parasuicide may decrease at 6 to 12 months. One study detected statistical difference in favour of people receiving DBT compared with those allocated to treatment as usual for average scores of suicidal ideation at 6 months. There was no difference for the outcome of leaving the study early. For the outcome of interviewer-assessed alcohol free days, skewed data are reported and tend to favour DBT. When a substance abuse focused DBT was compared with comprehensive validation therapy plus 12-step substance misuse programme no clear differences were found for service outcomes or leaving the study early. When dialectical behaviour therapy-oriented treatment is 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. 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. People who received treatment in a psychoanalytic orientated day hospital were less likely to be admitted

into inpatient care when measured at different time points . Fewer people in psychoanalytically oriented partial hospitalization needed day hospital intervention in the 18 months after discharge . More people in the control group took psychotropic medication by the 30 to 36 month follow-up, than those receiving psychoanalytic treatment. Anxiety and depression scores were generally lower in the psychoanalytically oriented partial hospitalization group, as are global severity scores. People receiving psychoanalytic care in a day hospital had better social improvement in social adjustment using the SAS-SR at 6 to 12 months compared with people in general psychiatric care. Rates of attrition were the same

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

Many Psychiatrists have reservations about the “**evidence-based**’ approach because of perceived limitations in methodology (Mundt & Backenstrass, 2001) Lehman & Steinwachs, 1998; National Institute for Mental Health, 1998), gaps in interpreting the available evidence and neglect of individual patient uniqueness in quantitative research through annualised treatment procedures (Beutler, 2000).

Concerning BPD the settings of the psychotherapy randomised controlled trials are highly artificial. 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 (Linnehans and Bateman’s) are not been effectively disseminated to the mental health professionals who deliver therapy around the world and thus are not readily available to the public who requires them (Barlow et al., 1999) (Goldfried, TD, Clarkin, Johnson, & Parry, 1999).

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 uptake, and investigations of 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 other plead to ad 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 courses of treatment response Lutz et al (Lutz, Lowry, Kopta, Einstein, & Howard, 2001) combines 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 evidence-based practice paradigm. Kendall et al (Kendall, Marrs-Garcia, Nath, & Sheldrick, 1999) proposes "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 more detailed psychopathology (thru data that can be expected from neurosciences) that can then be matched to specific psychotherapy tools (Mundt & Backenstrass, 2001).

3. Psychodynamic aspects

Certain authors who have compared these last two types of approach pointed out that, in the two approaches, the therapist is strongly committed even if the attitude of Kernberg is neutral and that of Linehan rather active with attitudes of reinforcement. The expression of aggressiveness is encouraged by Kern berg while Linehan does not encourage it. Linehan is not interested in the here-and-now of the group nor in group phenomena

Concerning the Therapeutic communities approaches, in the hospital milieu (and also in half-way institutions) the treatment is carried out in settings where several care-givers interact. Adshead (Adshead, 1998, 2000; Adshead & Bluglass, 2005) , in light of the theory of attachment, reported that the hospital milieu provides security only if care-givers are capable of tolerating both the external demands of the system and the internal demands of

patients. He pointed out that therapeutic relationships between staff and patients are only repetitions and recreations of internal object relations and that responses from the team to splitting and to projective identification can sometimes be negative. He points out that a certain number of negative reactions can be detected through the patronizing and contemptuous way the care-giver may sometimes express him- or herself to the patient ; that certain excessive reinforcements of the regulation of services, for example the inappropriate use of restriction on movement may be the result of this contrary attitude in personnel. He also remarks how to the conflict between therapist and patient comes to be added the new organization of cost containment, particularly in the managed-care system, the interference of insurance companies. Finally, he recalls that in problems in the organization of the structure of the unit, such as inadequate accounting practices, lack of leadership, difficulties in communication and violation of boundaries, can seriously aggravate the condition of patients.

The program developed in the Francis Dixon Lodge is an example of the above issues. The patients are generally hospitalized because of their destructive fashion of expressing their mental pain. After three weeks of hospitalization, they propose the psychodynamic formulation which includes predictions on transference reactions that we can expect and which try to cover the self-aggressive behavior (feelings of abandonment, trigger situation, etc.). They try to create a therapeutic relationship in which the patient feels sufficiently reassured to explore avenues of new relationships, while allowing him or her access to the horrors of the past which may carry so much negative emotion that they could even endanger the relationship. In addition, they consider that acting out is an expressive and defensive function and that even more self-destructive behavior can be an attempt to avoid another catastrophe (psychosis, heteroaggression, etc.) which can be experienced as more destructive to their own integrity.

These patients, because of their poor self-esteem, do not know how to ask for help in an appropriate manner, and do so in provoking crises, which causes the therapeutic team to counter-react. They explain to patients that they must learn to talk about their suicidal feelings or their ideas about self-mutilation. they explain to them that we try to be tolerant, but that we also expect them to modify their behavior. They try to avoid the feeling of omnipotence of patients when they trigger self-aggressive activities. They give special attention to phenomena of hostile and envious dependency, by trying to avoid or to manage

negative therapeutic reactions.

Initially two factors present in the course of treatment in certain psychiatric hospitals was recognized: "containment" (in Bion's sense) which furnish a feeling of security in the face of infantile pain, rage and despair which are frequently re-experienced in the therapeutic community and the "structuring the environment" to make it less uncertain and to facilitate modifications in ill-adapted behavior in the patient (Gunderson, 1983, 1994; Gunderson, 1999; Gunderson, Berkowitz, & Ruiz-Sancho, 1997; Gunderson & Chu, 1993).

Other factors entering into the efficacy of a therapeutic milieu have been described, notably: the "support" of whatever can foster patients' personal investment in the treatment plan to fight against passiveness; to promote acceptance of the expression of their pathology ("validation") which allows patients to assume their individuality. "Implication" is the mechanism through which patients are encouraged to interact with their environment, to escape from passiveness and collaborate.

These different mechanisms act in a specific fashion for different patients. Thus, containment can be necessary for borderline patients in an acute phase, confused and impulsive, but can have a negative effect later . Support can be very useful for depressed or frightened patients, but may be harmful for borderline patients. Validation can be very useful for paranoid and borderline patients but can be dangerous if they are suicidal patients

In addition, from a psychoanalytical point of view, certain ingredients derived from theories of relation to the object, of the psychology of the ego and group analysis represent the quintessence of therapeutic communities and explain their therapeutic effect with borderline patients.

In following a developmental sequence(Haigh, 1999; Hinshelwood, 1999; Hinshelwood & Skogstad, 1998) (Haigh, 1999; Hinshelwood, 1999; Hinshelwood et al., 1998), several therapeutic ingredients have been described of which the first was "attachment". The theory of attachment shows that if the link with the mother has not been reassuring, the adult will lack confidence in him- or herself, which is notably the case of certain patients suffering from borderline personality disorder. The therapeutic community creates a culture in which belonging is highly prized and where the members themselves are validated, which is reassuring for the patient. But, for an individual to develop, he or she must be able to confront other complex experiences, of love, hate, anger, frustration, sadness, attack, defense,

comfort, etc., facilitating disillusion regarding the fantasy of symbiotic fusion and early attachment and rendering the patient capable of « growing up and leaving home ». In this sense, the therapeutic community offers experiences of inclusion (a process of derivation and evaluation) and of departure (rituals of farewell, etc.).

Another fundamental therapeutic factor of development ((Haigh, 1999); (Hinshelwood, 1999)) is of course the already mentioned concept of "containment", which relates to the « mothering element » of these institutions. But there also exists a « paternal element » extremely important for borderline patients that consists in establishing limits and rules, in reinforcing boundaries, which contradicts in a certain fashion the notion of « permissiveness » demanded in a therapeutic community.

Once the therapeutic community has mastered primitive preverbal work with a patient, a fundamental challenge consists in establishing "communication", in the form of contacts with other patients and care-givers, which allows them to build mutual understanding through the use of "symbolic representations" and the process of "identification". For this, there must exist a "communal identity"(Rapaport, 1974) (Rapaport, 1974) which consists in a set of intimate relationships which are forged through the participation of all the members in therapeutic, social and informal activities in a « culture of enquiry ». Stable, protected groups with well-defined boundaries implement this process.

Another factor specific to therapeutic communities is represented by the compromise obliging patients to accept that all interpersonal interaction belongs to all the members of the community. Effectively, everything that goes on in the community can be utilized from a therapeutic point of view, leading then to an inseparable union between « living and learning » (Jones, 1972).

On the other hand, there exists, in therapeutic communities, a basic belief according to which the patient's unconscious is a better judge than the analyst's of the direction therapy should take, thereby bringing into play the notion that the most important therapeutic effect is brought into being by the patient, not by the therapist. The lack of symmetry between the therapist and the patient is accepted, but the automatic assumption of the therapist's superiority is rejected by most borderline patients. This attitude fosters accountability in patients who assume responsibility for their own therapeutic process, which facilitates its improvement but can be a source of ambivalence, for example engendering feelings of guilt.

The majority of severely affected borderline patients have a fragmented internal world, with a disorganization of their identity and of their mental processes. Disorganized institutions threaten to increase disorganization in their members who, in turn, will disturb the institution. Effectively, patients project their difficulties onto the community that surrounds them and introject elements of organization into that community. The concepts of "internalization of object relations" is essential in the treatment of borderline patients.

- Abrahms, D. B., & Niaura, R. S. (1987). *Social learning theories, Psychological theories of drinking and alcoholism*. New York: Guilford Press.
- Adshead, G. (1998). Psychiatric staff as attachment figures. Understanding management problems in psychiatric services in the light of attachment theory. *British Journal of Psychiatry*, 172, 64-69.
- Adshead, G. (2000). Psychological therapies for post-traumatic stress disorder. *Br J Psychiatry*, 177, 144-148.
- Adshead, G., & Bluglass, K. (2005). Attachment representations in mothers with abnormal illness behaviour by proxy. *Br J Psychiatry*, 187, 328-333.
- 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.
- Alexander, F. (1968). *Psychosomatic Specificity*. Chicago: University of Chicago Press.
- 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

