A new Time Limited Psychotherapy for BPD: Preliminary Results of a Randomized and Controlled Trial

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Introduction: Psychic Representation focused Psychotherapy (PRFP) is a new time limited dynamic psychotherapy for the treatment of Borderline Personality Disorder. It is a psychodynamic technique based on brief psychoanalytic psychotherapy principles. It is manualized and designed to be applied in the framework of public health care services. A randomized and controlled study with a sample of 53 patients was conducted to assess PRFP efficacy. This work presents the results for the first 44 trial completers at termination of treatment.

Methods: Both groups, the experimental (n= 18) and control group (n= 26), received treatment as usual. The experimental group received an additional 20 (PRFP) sessions, conducted by four therapists with homogenous characteristics specifically trained in this technique. The main outcome variables measures were: Severity global index of SCL-90-R, Barrat Impulsivity Scale scores and Social Adaptation (SASS score). Baseline and final condition at termination was compared.

Conclusions: Preliminary results showed significantly better outcomes for the experimental group in all the main variables measured and in most of the secondary ones. PRFP may represent an important contribution for the treatment of BPD patients. Follow-up assessment at 6 and 12 months is planned.

Keywords: Time Limited Psychotherapy, Borderline personality disorders, Manualized Psychotherapy, Randomized controlled trial

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Una nueva Psicoterapia Breve para Trastornos límite de la personalidad. Resultados preliminares de un Ensayo controlado y aleatorizado

Introducción: La Psicoterapia centrada en la Representación Psíquica (PCRP) es una nueva psicoterapia breve manualizada para los Trastornos Límite de la personalidad (TLP). Es una técnica psicodinámica basada en los principios de las psicoterapias psicoanalíticas breves, está manualizada y diseñada para su utilización en los servicios públicos. Con el objetivo de evaluar su eficacia en pacientes ambulatorios se realizó un estudio randomizado y controlado con una muestra total de 53 pacientes. En este trabajo se presenta la metodología del estudio y los resultados preliminares de los primeros 44 pacientes al final del periodo de intervención.

Metodología: Ambos grupos, experimental (n= 18) y control (n= 26), recibieron tratamiento convencional, el grupo experimental recibió además 20 sesiones de PCRP realizada por cuatro terapeutas con características homogéneas y especialmente entrenados. Las variables principales de resultados fueron: Índice global de gravedad del SCL-90-R y puntuaciones de la escala de Impulsividad de Barrat y Adaptación Social SASS, comparándose entre la situación basal y al final de la intervención en cada grupo y en ambos. Los resultados preliminares resultaron significativamente superiores en el grupo experimental en las variables principales y en la mayoría de las secundarias.

Conclusiones: La PCRP puede suponer un avance importante para el tratamiento de los TLP si se confirman los resultados preliminares con los datos finales del estudio. Éstos se presentarán una vez finalizado el mismo incluyendo la evaluación en el seguimiento a los seis y doce meses.

Palabras clave: Psicoterapia breve, Trastorno límite de la personalidad, Psicoterapia manualizada, Ensayo controlado y aleatorizado

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INTRODUCTION

Borderline personality disorders (BDP) continue to generate great interest in the clinical setting because of the need to elucidate their etiopathogeny and to have effective and accessible treatments. Pharmacological treatment is not specific and a single treatment of choice has not yet been demonstrated.[1-3] Psychotherapy continues to be a core treatment element, both alone and combined with psychopharmaceuticals.

In the last decade, several controlled studies have shown the efficacy of four types of manualized, long-duration psychotherapy for the treatment of BPDs. Two of them are based on the principles of psychodynamic psychotherapy: Transference Focused Psychotherapy (TFP),[4-6] and Mentalization-based Psychotherapy (MBT).[7,8] The two other modalities are based on the principles of cognitive-behavioral psychotherapy: Dialectic Behaviour Therapy (DBT)[9-11] and Schema Focused Psychotherapy (SFT)[12,13]. Efficacy refers to the improvement of the variable number of symptomatic areas of the aspects characteristic of the disorder, especially in suicidal and self-injury behavior.[14] In every case, these are psychotherapies that require a minimum of 12 to 18 months treatment with a frequency of one or two sessions per week.

It stands out that the treatment dropout numbers are elevated in all of the previous mentioned modalities.[6,12,15] On the other hand, and in spite of their proven efficacy, these psychotherapies are not very accessible to most of the patients. In a comparative analysis between them recently conducted by Zanarini,[14] the need to advance in the development of shorter psychotherapy techniques to facilitate access to a greater number of patients was proposed. Paris[16] even proposes the hypothesis that treatment with intermittent short therapies could solve the problems of adherence in to prolonged treatments.

In this context, it is reasonable to study the possibilities offered by short-term Dynamic Psychotherapy for the treatment of BPD. However, there are few randomized and controlled studies of Brief Dynamic Psychotherapy of Personality Disorders. The most recent meta-analysis carried out by Leichsenring[17] only included five randomized and controlled studies on Personality Disorders. Of these, two referred to cluster C disorders,[18,19] two to Personality Disorders in general,[20,21] and only one study was specific for BPDs, but it referred to brief group psychotherapy. [22]

A limited number of randomized Clinical Trials with short-term dynamic psychotherapy include Borderline Disorders in the Personality Disorders samples, so that the studies for this group are not very conclusive. Such is the case in a study of supportive-expressive psychotherapy having limited time (40 sessions) compared to non-manualized dynamic psychotherapy[23] and another one of intensive short-term dynamic psychotherapy (ISTDP) of Davanloo.[24]

In the field of the cognitive-behavioral model inspired therapies, attempts have been made to apply the reduced format of DBT of 20 sessions in a series of cases with good results in regards to the decrease of the self-injury intentionality with very therapeutic adherence being much greater than that found in conventional DBT studies.[25] Along the same line, Bellino et al.[26] have tested an Interpersonal Psychotherapy adapted to depressive disorders with comorbidity with BPD with a duration of 30 sessions. The STEPPS program[27] can be considered a short form of group psychotherapy and it has been studied in comparison to conventional treatment with good results.

Considering the available evidence on the efficacy of brief psychotherapy in some personality disorders, on the one hand, and on the evidence of the efficacy of long-duration dynamic psychotherapies in patients with BPD on the other, our work group has developed a manualized technique of brief psychotherapy for this type of patient called Psychic Representation focused Psychotherapy (PRFP). PRFP is a time-limited psychotherapy based on the general principles of psychodynamic oriented psychotherapy. Its core element is the work with psychic representation capacity of oneself and of the significant objects and their link with the corresponding affects. This is a structured and manualized technique with a focal character. Due to its own nature, it can be directed towards limited therapeutic objectives and is indicated in outpatients. This technique has been developed within the public health care setting with the objective of being effective, efficient, and accessible for an extensive number of patients.

This study has been designed to test the hypothesis that combined treatment with PRFP plus CT (Conventional Treatment) is more effective than CT in borderline personality disorders in decreasing global severity of the symptoms, specific improvement of the groups of symptoms characteristics of the disease such as depression, anxiety, self-injury ideation, impulsiveness and low self-esteem and in the achievement of improvement in the grade of social adaptation.

The study methodology and preliminary results corresponding to the first 44 patients of the total sample at the end of the intervention period is presented in this work.

METHODOLOGY

Design: experimental, controlled, randomized and open study in patients with Borderline Personality Disorder (BPD) in outpatient regime.

Study sample: Fifty-three subjects diagnosed of BPD attended in the outpatient services of the Hospital Clínico

San Carlos and Hospital Universitario 12 de Octubre of Madrid were included in the study. The patients were recruited consecutively over a 12 months period in accordance with the following criteria: clinical diagnosis of BPD following the DSM-IV-TR criterion made by the treating psychiatrist during the selection phase and using the SCID-II[28] interview in the inclusion phases, age 18 to 50 years, having a clinical situation of outpatient treatment and having accepted the study conditions by informed consent. The exclusion criteria were: having active suicide risk symptoms, violent or unmanageable heteroaggressive behaviors on the outpatient level at the time of recruitment, comorbidity with diagnosis of Eating Behavior Disorder on Axis I, with Toxic Dependence Disorder or current severe physical disease. Toxic consumption was accepted.

The subjects who met the inclusion criteria were assigned to one of the two intervention groups through the generation of simple random sampling through a sequence of randomized numbers generated with EPIDAT 3.1.

Exclusion criteria during the intervention phase were subjects who interrupted their psychotherapy for more than four consecutive sessions without justification or for more than six sessions in any case were excluded.

DESCRIPTION OF THE INTERVENTIONS

The experimental group received PRFP for 20 weekly sessions in addition to conventional out-patient psychiatric treatment. The control group only received conventional treatment without specific additional psychotherapy for six months.

Psychic Representation focused Psychotherapy (PRFP)

This is time limited manualized psychodynamic psychotherapy developed by the research group. As other dynamic psychotherapies, PRFP is based on classical psychoanalytic principals and on characteristics per se of brief psychotherapies. In addition to these principles, PRFP adds work focused on distorted psychic representations and their link with the corresponding affects and emotions.[29,30] These phenomena (distorted representations and their corresponding affects) contribute to the development and maintenance of some core symptoms in the borderline personality disorders, especially impulsiveness, rage, feelings of emptiness and depressive manifestations.

The principal strategies of the therapy are the following:

- Lead the therapy in accordance with the objectives established in the evaluation.
- Identification of the pathological impulses and underlying emotional states. The therapy tries to establish connections between the painful emotional states experienced by these patients and the object representations. This task is done by facilitating acquisition of rational awareness of the process of connection and/or evocation of representations and affects.[29]
- Identification of the most evolved elements of the patient's personality and identification of representations of sufficiently valid early object links.
- Clarification and reinforcement of the movements of affective approach to others and of their cathexis.
- Therapeutic management of the time limit during the therapy.

The core elements of the therapy process are the following:

- Establishment of therapeutic alliance and commitment with the patient.
- Strengthening of their desire to change and systemic examination and support on positive affective links that permit the patient to initiate the therapeutic relationship.
- To offer the patient a psychic representation of this desire for change. Early analysis of the ambivalence regarding desire for help and change, oriented towards consolidating the alliance and favoring the creation of a realistic and adequate intersubjective link that acts by restraining the patient's affectivity by providing him/her with a systematic, rigorous and respectful setting. Systematic work on the finalization of the therapy and object permanence.

Technical elements

A total of 20 face-to-face, 45-minute long, consecutive weekly sessions were carried out, at with a predetermined hour, place and conditions. The sessions were recorded in video or audio to perform the necessary adherence controls.

The therapists who participated in the experimental treatment included 4 psychiatrists and 1 clinical psychologist. All had at least 8 years of training in standard psychoanalytic psychotherapy and had at least 15 years of professional practice as therapists.

Treatment homogeneity and adherence to the technique were guaranteed by external control of an expert psychiatrist in psychodynamic psychotherapy, with experience in personality disorders and in research in psychotherapy. The supervision method consisted in random control by the external supervisor of the project of five sessions of each psychotherapist.

Conventional treatment

The psychopharmacological treatment was conducted in accordance with the standard applied in the Hospital Clínico San Carlos. This was based on the combination of three types of drugs according to the presence and intensity of three types of symptoms. If there were depressive symptoms, the first choice of treatment was an SSRI antidepressant and the second choice was that of a dual action antidepressant (SNRI). If there were impulsivity symptoms, a mood state stabilizer (first choice Topiramate, second choice Gabapentin) was used. If there was no response, low doses of an atypical antipsychotic were indicated (first choice Olanzapine, second choice, another atypical antipsychotic drug). If there were heteroaggressive symptoms, the previous antipsychotic regime was used. The three types of drugs were administered simultaneously at variable doses or independently according to the predominant symptoms. In addition, the patient could receive non-standard out-patient psychological advice in the office. The person responsible for the conventional treatment was a psychiatrist who was not acting as the psychotherapist. Any type of standard psychotherapy was excluded in the control group.

Study variables

The principal study variables were measurements of the severity of the general symptoms and of impulsivity using the scores on the following standardized scales: Severity Global Index of SCL- 90-R,[31] Barrat Impulsivity Scale[32] and self-applied Social Adaptation Scale, SASS.[33] As secondary result variables, the scores were recorded on the following scales that evaluated other characteristic symptoms of the disorder: Zanarini Rating Scale for Borderline Personality Disorder,[34] Clinical Global Impression Scale-CGI,[35] Montgomery-Asberg Depression Rating Scale (MADRS),[36] State-Trait Anxiety Inventory (STAI)[37] and Rosemberg Scale for the evaluation of Self-Esteem.[38] Suicidal intentionality was evaluated using the variation in the corresponding item on the Montgomery-Asberg Scale.[36] On the other hand, modifications in drug treatment after the initial moment of the study were taken into account.

The independent study variables were the following: sociodemographic (age, gender, civil status, maximum school level reached, sociolaboral occupation, occupation of father, type of living arrangement, type of upbringing of the subject (upbringing in family of origin, with other family members, in an institution, adoption), presence or not of diagnosis on Axis I of the DSM-IV classification and type, psychopharmacological treatment in the inclusion phase in the study and profile of personality traits, measured using the Eysenk personality questionnaire.[39]

Follow-up

The independent variables were collected prior to the onset of the intervention. The dependent variables were recorded before and after the intervention period. Measurement in the follow-up phase was performed at 6 months and 12 months after completing the intervention.

Statistical analysis

The statistical analysis was done by intention to treat. Qualitative variables are shown with their frequency distribution and quantitative variables are summarized with their mean and standard deviation (SD).

In the comparison of the baseline characteristics of the groups, the association between qualitative variables was evaluated with the Pearson χ^2 test or Fisher exact test. For the quantitative variables, the means were compared using the Student's t-test for independent groups.

For the statistical analysis of the principal and secondary outcome variables, the lacking data were replaced by the value obtained in the *last observation carried forward* in the subjects who were lost to follow-up in both study groups.

The intra-group comparisons of the change in the scores from the post- and pre-intervention time were obtained with the Student's t test for paired samples.

The differences for the variables of the principal and secondary outcome between the treatment groups between the baseline time and at the end of the intervention (end of the PRFP or 6 months of conventional treatment) were evaluated with the variance analysis (ANOVA) for repeated measures, introducing the study group as inter-subject factor.

Given that the sample size was not estimated *a priori* due to the absence of published data on the efficacy of brief dynamic psychotherapy, the potency of the differences observed in the sample for the principal outcome variables was calculated. A significance value of 5% was accepted for all the tests. Data processing and analysis was performed using the SPSS 15.0 statistical program .

Potency

Potency for Barret Scale was 75%, for the SCL-90 Scale 67%, and for the SASS Scale 86%.

RESULTS

A total of 63 subjects were recruited for the study. Ten of them were excluded because they did not fulfill the inclusion

criteria. Finally, 53 were randomized, 25 being assigned to the experimental group and 28 to the control group. There were 7 drop-outs in the intervention period: 4 in the control group and 3 in the experimental group. Causes for abandonment in the experimental group were two cases due to change of residence after having received three and four sessions, respectively, and one case due to lack of satisfaction with the care received before beginning the sessions. One patient of the control group was excluded because the diagnosis was changed during the treatment period. Cases of abandonment in the control group were due, in every case, to lack of satisfaction because they had been randomly assigned to this group. The inclusion process and progress in the study are shown in the diagram of figure 1.

The preliminary results of the first 44 patients of the study who completed the intervention phase are shown. The subsample included 70% women, with mean age of 33.8 years (SD 7.5). The control group was made up of 26 patients and the experimental one 18.

The sociodemographic and clinical characteristics of the patients are shown in Table 1. No significant differences were observed in the baseline evaluation of both groups, both in regards to the independent and dependent sociodemographic and clinical variables. In regards to the sociodemographics aspects, the subjects were characterized by being mostly single, with a middle education level, predominance of working in jobs having low technical or intellectual requirement. One third of the sample worked, one third were unemployed and approximately 15% were receiving a sickness-based pension.

Clinically, approximately 50% had a concomitant psychiatric condition on Axis I of the DSM-IV classification. All of the sample subjects were receiving drug treatment, 90% of whom were receiving anti-depressants, more than 40% mood stabilizers and 30% antipsychotics.

The comparative results between the baseline data and those at the end of the intervention period are shown in Table 2. Clinical improvement was observed in both groups when the baseline situation was compared with the end of the intervention period in accordance with the measurements of all the variables regarding disease symptoms, except for social adaptation measured with the SASS scale. The latter increased in the control group and very significantly decreased in the experimental group. The improvement of the experimental group was significantly greater in accordance with the principal outcome variables: SCL-90 severity index, CGI, Barrat Impulsivity Scale and SASS social adaptation scale.

Considering the sample obtained up to the time of the analysis, the potency of the contrast hypothesis to find this effect measurement for the principal outcome variables was 75% for Barrat Impulsivity Scale, 67% for the SCL-90 severity index and 86% for the SASS disability scale.

Furthermore, the clinical improvement was significantly greater in the experimental group in accordance with the

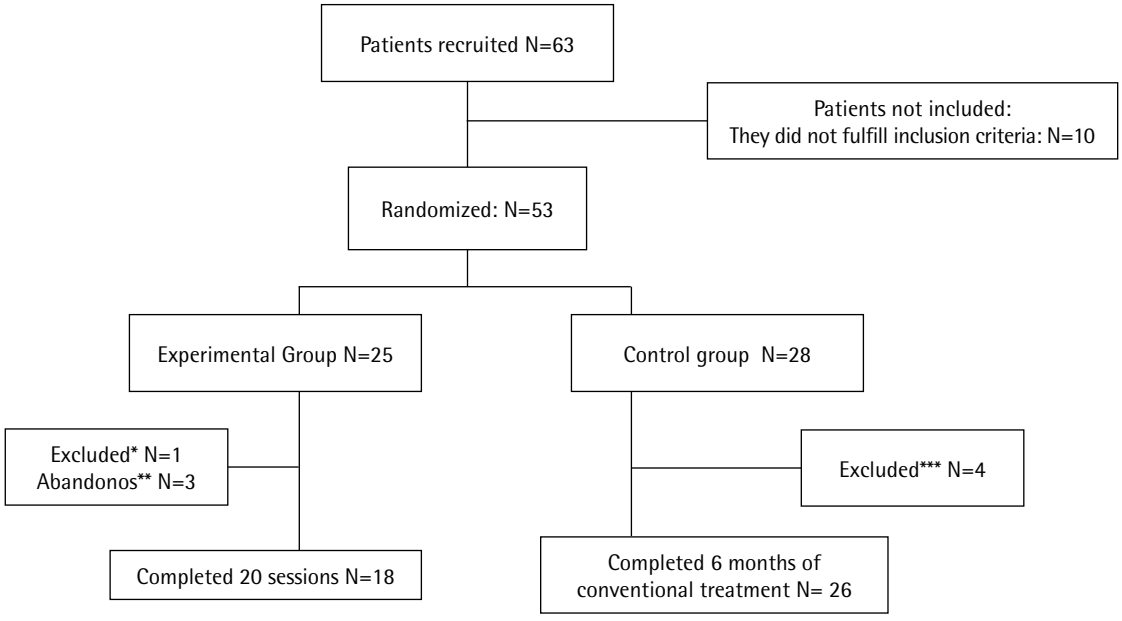

Figure 1 *Progression of the patients during the randomized and controlled study comparing PRFP (20 session) plus conventional treatment (CT) versus conventional treatment (six months). Preliminary results of the first 44 patients*

Table 1 **Baseline social demographic and clinical characteristics according to the treatment group assigned**

Variables		Experimental Group (N=18)	Control group (N=26)	Total (N=44)	p
Age*					
Woman %		66.7	73.1	70.5	0.647
Civil status %	Single	61.1	73.1	68.2	0.128
	Divorced	38.9	15.4	25.0	
	Married	0.0	11.5	6.8	
Living arrangement %	Lives alone	27.8	30.8	29.5	0.956
	Partner with/without children	33.3	34.6	34.1	
	Family of origin	38.9	34.6	36.4	
Is father/mother %		27.8	26.9	27.3	0.950
Schooling %	Primary education	27.8	15.4	20.5	0.214
	Secondary education	27.8	53.8	43.2	
	Graduate	44.4	30.8	36.4	
Occupation/Employment %	Technicians/ professionals	27.8	15.4	20.5	0.576
	Assistant administrative/ / office workers/ business	22.2	30.8	27.3	
	Waiters/construction workers/ transport services	50.0	53.8	52.3	
Work situation %	Working	44.4	30.8	36.4	0.759
	Unemployed	22.2	38.5	31.8	
	Pensioner	16.7	11.5	13.6	
	Student	5.6	3.8	4.5	
	Temporary disability	11.1	15.4	13.6	
With diagnosis on axis I of the DSM IV %		44.4	50.0	47.7	0.717
Psychopharmacological treatment %		100.0	100.0	100.0	-
Antidepressants %		88.9	92.3	90.9	1.000
Mood stabilizers %		55.6	34.6	43.2	0.168
Antipsychotics %		38.9	19.2	27.3	0.183
Benzodiazepines %		72.2	73.1	72.7	1.000
Eysenck neuroticism*		21.2 (2.2)	20.6 (3.8)	20.8 (3.2)	0.547
Eysenck extroversion*		7.6 (5.3)	9.0 (5.6)	8.4 (5.4)	0.399
Eysenck Psychoticism*		5.0 (2.5)	5.8 (3.1)	5.5 (2.9)	0.341
Eysenck sincerity*		14.4 (4.8)	14.2 (4.3)	14.3 (4.5)	0.888

* data presented with mean and standard deviation (SD)

secondary outcome variables: Zanarini scale (global score), depressive symptoms according to the MADRS, suicidal ideation (suicide item of the MADRS), self-esteem (Rosemberg scale) and disability measured with the SASS. Improvement in the anxiety state was greater in the experimental group, this being close to statistical

Table 2 Outcome variables. Differences between the baseline and final situation of the intervention

	Experimental Group (N= 18)			Control Group (N=26)			Inter-groups	Effect size***
	Pre (SD)	Post (SD)	P*	Pre (SD)	Post (SD)	P*	P**	
SCL 90	1.9 (0.4)	1.2 (0.7)	<0.001	1.9 (0.8)	1.7 (1.0)	0.079	0.016	0.78
ICG	4.7 (1.0)	3.4 (1.5)	0.008	4.6 (0.9)	4.1 (1.0)	0.045	0.101	0.79
Zanarini total score	22.8 (5.4)	13.0 (7.9)	0.001	23.4 (5.7)	19.1 (6.9)	<0.001	0.026	0.97
MADRS total score	28.7 (6.6)	15.9 (13.2)	<0.001	24.6 (9.9)	22.8 (11.2)	0.295	0.001	1.25
MADRS Suicide score	2.4 (1.1)	1.2 (1.7)	0.003	1.7 (1.5)	1.7 (1.7)	1.000	0.006	0.88
STAI state score	36.2 13.6)	24.5 14.2)	0.003	35.4 (16.1)	32.5 (15.9)	0.337	0.063	0.57
Rosemberg score	12.3 (3.5)	18.1 (7.2)	0.003	10.8 (7.6)	11.7 (8.0)	0.452	0.019	0.77
Barratt score	63.2 12.8)	52.5 16.7)	0.002	69.3 (17.7)	68.2 (19.5)	0.624	0.009	0.61
SASS score	30.6 (6.7)	35.4 (8.9)	0.007	29.6 (9.6)	27.6 (10.8)	0.104	0.001	0.80
Zanarini dropout	2.8 (0.8)	1.5 (1.1)	0.003	2.7 (1.0)	2.3 (0.9)	0.067	0.027	0.96
Zanarini relations	3.2 (0.8)	1.9 (1.1)	<0.001	2.8 (0.9)	2.3 (0.9)	0.013	0.029	0.83
Zanarini identity	2.9 (1.0)	2.0 (1.2)	0.035	2.9 (0.9)	2.3 (1.1)	0.013	0.521	0.28
Zanarini Impulsivity	2.6 (1.3)	1.6 (1.3)	0.006	2.7 (1.0)	2.3 (1.2)	0.090	0.166	0.52
Zanarini suicidality	2.1 (1.4)	0.9 (1.2)	0.012	2.3 (1.3)	1.3 (1.3)	0.001	0.666	0.14
Zanarini affective instability	2.9 (0.9)	1.9 (1.2)	0.017	2.9 (0.9)	2.6 (1.0)	0.039	0.131	0.51
Zanarini feeling of emptiness	2.9 (0.8)	1.8 (1.3)	0.004	3.1 (0.9)	2.7 (1.1)	0.013	0.046	0.84
Zanarini rage	2.2 (1.0)	1.6 (1.2)	0.158	2.5 (0.8)	2.6 (1.1)	0.656	0.123	0.79

SCL: Severity Global Index of SCL-90; CGI Clinical Global Impression Scale; MADRS: Montgomery-Asberg Depression Rating Scale; STAI: State-Trait Anxiety Inventory; SASS: Social Adaptation Self-evaluation Scale

* Student's t for paired data

** End of intergroup interaction of the analysis of variance (ANOVA) for repeated measurements

*** Effect size was estimated by dividing the difference between groups of absolute change, in terms of improvement, at the end of follow-up, between the baseline combined standard deviation

significance. The same can be said regarding clinical improvement according to the CGI.

DISCUSSION

The study preliminary results show that improvement was greater in the group that received PRFP than in the control group for the principal outcome variables, that is, in severity of the general symptoms, in level of impulsivity and in grade of social adaptation. Potency of the contrast hypothesis with the instruments used in the principal variables was close to or greater than 0.80 in every case.

There was a substantial decrease in global severity of the symptoms in the experimental group when measured with the SCL-90. This result is comparable to the various controlled and randomized studies of different forms of BPD psychotherapy.[6,23] Severity measured using the CGI, although it also shows an important decrease in the experimental group versus the control, was not statistically significant. However, it is true that this is a general measurement of subjective severity given by the psychiatrist SCL-90 which is an objective measurement that is not influenced by the opinion of the clinician.

The measurement of the specific symptomatic severity of the disorder, evaluated with the Zanarini scale[34] is also a subjective measurement of the clinician, although it is focused on the specific symptoms and shows a significant difference in favor of the experimental group. The data indicate that the feelings of abandonment, alterations in the

interpersonal relations and feelings of emptiness are those that show more significant improvement among the nine evaluated by the scale. The STEPPS Program[27] also showed a positive result compared to the conventional treatment measured with the Zanarini scale. In this case, improvement also referred to interpersonal relations, feeling of abandonment and impulsivity. On the contrary, this type of psychotherapy was not superior to the conventional treatment in the severity of the general symptoms.

The group that received the PRFP improved significantly more than the control group regarding the depressive symptoms measured with the MADRS scale. This is an effect observed in some efficacy studies of time-limited[8,26,27] and long duration[8] psychotherapy in BPD. Along the same line of the affective symptoms, a very significant improvement was observed in the self-esteem level measured with the Rosemberg scale. This finding is very important since self-esteem of patients with BPD is very weak and this fragility generates much suffering in the patients, acting as a pathogenic factor.

In our study, the suicide ideation item of the MADRS scale was specifically evaluated. The improvement experienced in the psychotherapy group was also superior to the control group. This improvement is congruent with the decrease of the depressive symptoms, increase of self-esteem added to the decrease of impulsivity. Most of the psychotherapies for BPD evaluated up to date by randomized controlled clinical trial (RCTs) have demonstrated their efficacy, above all in the decrease of suicidal and self-injury behaviors.[6,8,11,15,26] This effect has also been observed in the preliminary results of the RCT. However, other clinical symptoms show an improvement of the same dimension. It is to be expected that there would be a decrease in suicidal and self-injury behaviors along with the decrease of impulsivity, on the one hand, and of the depressive symptoms on the other.

In our preliminary results, their was a significant decrease in impulsivity in accordance with the initial hypothesis. The principal objective of the PRFP is to contribute to the decrease of impulsivity by two mechanisms: first, decrease and restraint of adverse emotional reactions when faced with situations that are interpreted as abandonment or as under evaluations. In the secnd place, because of an increase in the capacity of psychic representation which, in accordance with the Bender and Skodol criterion[40] is functionally decreased in these patients. Such representation capacity, in psychodynamic terms, could lead to greater prefrontal inhibitory capacity of impulsive behaviors in negative emotion situations.[41-43] This control should be translated into greater reflexive capacity which, by itself, is a modulating factor for impulsivity.

Although this study was not designed to establish process-result correlations, it must be recognized that the positive results obtained only make up indirect measurements of the capacity of psychic representation. That is, at present, it is not possible to state that specific components of psychotherapy are responsible for the good clinical results. In the future, it will be necessary to develop some specific measurements of the capacity of psychic representation and of reflection for this purpose.

Personality borderline disorder is associated to significant disability. In our study, the disease-associated disability significantly improved in the group that received psychotherapy on the contrary to mild deterioration in the control group. Other long-term psychotherapies in outpatient regime also have been shown to decrease the disease-associated disability at the end of the intervention.[6-8,10,15,23] On the contrary, no time-limited term psychotherapy has shown this effect in the BPDs except for intensive short term psychotherapy of Davanloo in a heterogeneous sample of personality disorders.[24]

In accordance with Kazis' interpretation,[44] effect size was very robust for the outcome variables and most of the secondary variables: CGI, MDRS (total score and suicide item), Rosemberg and SASS. It was moderate for Barratt and STAI state.

Another interesting element to keep in mind in these preliminary results is that regarding the numbers of treatment dropouts. One of the most relevant problems in the treatment of these patients is their difficulty to maintain adherence to it. In our preliminary results, dropouts were 20% in the experimental group and 18% in the control group. In several published studies, dropout values exceeding 20% have been reported.[6,8]

The abandonments occurred in the first four treatment sessions in the experimental group. In two cases, this was due to an unexpected change of residency and was only due to lack of satisfaction with the attention received in one case. In the control group, the reasons for abandonment were expressed as disagreement with not having been included in the experimental group, in spite of knowing the study conditions and having signed the consent to participate. Although all the studies with psychotherapy for this type of condition show an abandonment proportion greater than 20%, no conclusions can be drawn given the limitation of the results. It is necessary to wait until the end of the study and follow-up.

The preliminary results of this study point to the fact that significant improvement can be obtained in different areas of symptoms and functionality in patients who suffer BPD in a limited time, using dynamic therapies, added to conventional treatment.

Faced with the efficacy, the fact that the patients who have been included in the study represent a typical sample

of public out-patient care in Spain, supports the possible effectiveness of the therapy. If these results are confirmed, PRFP would represent an effective, efficient and accessible therapeutic model for a large number of patients with BPD who come to our out-patient clinics.

LIMITATIONS OF THE STUDY

The results presented herein should be interpreted within the context of the limitations of this study. These limitations are various: first, these are partial and preliminary results. Therefore, the sample size is small. Furthermore, we still do not have the follow-up data. In the second place, this is a study that is not blind for the investigators and patients due to the inherent difficult in trials with psychotherapy. In the third place, this is the first study conducted with this technique. To draw more solid conclusions, it is necessary to wait until complete data of the study is available, including the follow-up and after to extend the study to larger samples.

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CONFLICT OF INTERESTS

No author has any conflict of interests.

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