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Mexican Journal of Medical Research ICSa

Biannual Publication, Vol. 12, No. 24 (2024) 46-57

ISSN: 2007-5235

Borderline Personality Disorder: Effectiveness of Evidence-Based Therapeutic Interventions

Trastorno Límite de la Personalidad: Efectividad en Intervenciones Terapéuticas Basadas en Evidencia

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Abstract:

Borderline Personality Disorder (BPD) is a complex and heterogeneous disorder, characterized by instability in emotion regulation and alterations in interpersonal relationships and self-image. Studies conducted over the last few years have assessed the efficacy of various psychotherapeutic strategies for reducing specific symptoms and treating the disorder. This paper aims at reviewing the theoretical and technical characteristics of evidence-based psychotherapies that have shown effectiveness in the treatment of Borderline Personality Disorder (BPD). The models reviewed are Dialectical Behavior Therapy (DBT), Mentalization-Based Therapy (MBT), Transference-Focused Psychotherapy (TFP), and Schema Therapy (SCT). An analysis of the evidence-based interventions specifically designed for the treatment of BPD is being conducted, and a review of the comparative efficacy of some of them. There are differences in the interventions according to the factors in which each has the most impact, this can contribute to making informed decisions about treatment choices based on the specific interest of each researcher or the needs of each case, achieving a broader and more functional view of the disorder, primarily focused on the patient. Scientific evidence allows us to recognize that psychotherapies with a more structured design and operation have significantly greater efficacy both for improving specific symptomatology and the overall BPD nosological picture. Lastly, studies showing the neuropsychological correlates of applying some treatments are included.

Keywords:

Treatments, Borderline Personality Disorder, Effectiveness, Impulsivity

Resumen:

El trastorno límite de la personalidad es un trastorno complejo y heterogéneo, caracterizado por una inestabilidad en la regulación de las emociones y alteraciones en las relaciones interpersonales y en la autoimagen. En estudios realizados durante los últimos años diversas investigaciones han valorado la eficacia de distintas estrategias psicoterapéuticas para la disminución de síntomas específicos y el tratamiento del trastorno en sí. El objetivo de este trabajo es llevar a cabo la revisión de las características teóricas y técnicas de las psicoterapias basadas en evidencia que han mostrado efectividad en el tratamiento del Trastorno Límite de la Personalidad (TLP). Los modelos revisados son la Terapia Dialéctica Conductual (TDC), Terapia Basada en Mentalizaciones (TBM), Psicoterapia Focalizada en la Transferencia (PFT) y la Terapia de Esquemas (TE). Se realiza un análisis de las intervenciones basadas en evidencia diseñadas específicamente para el tratamiento del TLP, así como una revisión de la eficacia comparativa de algunas de ellas. Existen diferencias en las intervenciones según los factores en los que cada una tiene mayor impacto, esto puede contribuir a tomar decisiones informadas sobre las opciones de tratamiento en función del interés específico de cada investigador o las necesidades de cada caso, logrando una visión más amplia y funcional del trastorno, centrándose principalmente, en el paciente. La evidencia científica permite reconocer que las psicoterapias que cuentan con un diseño y una operatividad más estructurados, tienen significativamente mayor eficacia, tanto para mejorar la sintomatología particular como del cuadro nosológico general del TLP. Por último, se incluyen estudios que muestran los correlatos neuropsicológicos de la aplicación de alguno de los tratamientos.

Palabras Clave:

Tratamientos, Trastorno Límite de la Personalidad, Efectividad, Impulsividad

INTRODUCTION

According to section II of the Manual of Mental and Statistical Disorders (DSM-5)[1], Borderline Personality Disorder (BPD) is characterized by the presence of a persistent pattern of affective, interpersonal and self-image instability, as well as a dichotomous and radicalized view of reality and major failures

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Received: 08/03/2024, Accepted: 09/05/2024, Postprint: 10/05/2024, Published: 05/07/2024

DOI: https://doi.org/10.29057/mjmr.v12i24.12449

in the ability to achieve adequate socialization, the above derived from a high degree of impulsivity and inappropriate anger and failures in the development of assertive social skills.[1-3] This disorder has a regular onset of symptoms in adolescence and diagnostic conformation in the early stages of adulthood[4-8]; interferes in various contexts, however, the origins of the disorder can be traced back to experiences of impact, confusion, and emotional mismatch during childhood.[9,10] The disorder has presented difficulties in its clinical approach and therapeutic management since its inclusion in the Diagnostic and Statistical Manual in its 3rd version (DSM-III)[11] and confusion regarding its conceptualization and conception as a psychopathology since 1938 when it was understood that the disorder was a middle ground between pathologies proper to neurosis and psychosis.[12] Besides the complications presented by the conceptualization of the disorder, it is important to mention that one of the characteristics that complicate its diagnosis is having a high comorbidity, especially with the symptoms of depression, anxiety, and paranoid states, as well as that many of the people who present the disorder generate transient delusions and severe dissociative symptoms.[1,13]

The difference between previous psychological and contextual conditions in patients particularizes how this disorder is manifested. According to their descriptions, both DSM -5 and the International Classification of Diseases, 10th Revision (ICD-10) open up a wide range of possible symptoms considered for diagnosis.

According to 2023 data obtained through the Ministry of Health in Mexico, in some years BPD could become a significant public health problem[14]. Statistically, it is the most common personality disorder in the world[1]; this disorder begins in adolescence and mostly diagnosed in adulthood.

Studies on prevalence indicate that between 76 and 80% of cases occur in women[1] and can be a disabling pathology due to its clinical characteristics that include a pattern of unstable social relations and high impulsivity, leading those who suffer from the disorder to present multiple risk and self-harming behaviors.

It is important to mention that, despite the existence of epidemiological data on the disorder, there is a general lag, not only in Mexico but throughout Latin America, concerning prevalence data, diagnostic methods, and treatment protocols for mental disorders in general, especially of those that begin to develop during childhood and adolescence and that do not show evidence of organic damage, this is the case of BPD.[14]

According to the above, we can understand the diagnostic difficulty of the disorder, both in the differential aspect and in its delimitation. However, this is not the only obstacle to consider for the clinical approach in patients with BPD, since we also encounter difficulties in establishing an effective treatment for the disorder, especially making informed therapeutic decisions may be the biggest challenge. The choice of treatment cannot be based solely on the consideration of symptom remission or reduction. We must also take into account the difficulties that arise from dealing with Borderline Personality Organization. These include factors such as high dropout rates, lack of compliance with therapy the patient's emotional instability, black-and-white thinking, irritability, and the patient's struggle to adapt to and accept treatments. On the other hand, according to the characteristics of patients with BPD, injuries, self-injury, substance intoxication, and the highest level of risk, suicide attempts are frequent in these patients, and are not rare in the disorder. Sometimes, the need to use emergency medical services[15] is common or constant. The above can also translate into high institutional costs and the obvious difficulties in their psychological care.[16]

Traditionally, two complementary approaches have been selected for treating mental pathologies, one medical-pharmacological and the other psychological-therapeutic. While pharmacotherapy aims to regulate brain chemistry that modifies mood, psychotherapy acts by resolving problems and conflicts that have an impact on behavior. Regarding the latter, psychotherapy has been used since the beginning of the clinic for treating mental disorders.[17] It has proven the effectiveness of its interventions, as stated in the Resolution of the American Psychological Association (APA), on the effectiveness of psychotherapy in the treatment of mental illness[18], which compiles more than 140 quality studies and meta-analyses that support the effectiveness of psychotherapy in controlled clinical trials and in real contexts, as well as the results obtained in various populations. It also states that different psychotherapies are more or less effective in treating different disorders.[19] In general, there are few studies on the impact of psychotherapies in the Mexican population and, above all, studies that evaluate the effectiveness of treatments in specific psychopathologies.[20] It is also important to understand how psychological, biological, and social factors can contribute to resolving issues about the effectiveness of BPD treatments.

Research indicates that more than 80% of the Mexican population that suffers from a mental disorder does not receive adequate, specialized, or timely treatment, exposing the population to the worsening of pathologies.[14,19]

Only in recent years has it been possible to carry out research that sheds evidence on the efficacy of psychotherapy specific to BPD treatment, highlighting four of them, two of cognitive-behavioral nature: Dialectical Behavioral Therapy (DBT) and Schema Therapy (ST) and two with a psychodynamic approach: Transference Focused Psychotherapy (TFP) and Mentalization Based Therapy (MBT). Other treatments have also been tested for the disorder with less effectiveness according to studies, or with little information regarding its implementation.[2]

It is important to highlight the lack of information on applying these psychotherapies in a general way in the Spanish-speaking population and specifically in Mexico, which is why there is a lack of information about their implementation in their particular sociocultural and psychological situation. In the specific case of the state of Hidalgo, although there are 87 Basic Mental Health Modules[21], there is no information about the use

of specialized treatments in people suffering from BPD, in addition to not having trained or trained personnel in any specific psychotherapy to carry out the treatment of the disorder. Generally, in the state of Hidalgo, there is a small number of professionals, trained or in training, to perform treatments using specific therapies.

Public health prevention policies aimed at treating BPD can also contribute to challenging and reducing the stigma associated with mental disorders. Creating greater public awareness and understanding fosters a regional environment where people feel more comfortable seeking help and support.

Adequate prevention practices in public health can address inequalities in access to care. Low-income people, marginalized communities and other vulnerable groups often face barriers to accessing quality mental health services. Improving public health policies for treatment could help reduce the consequences of the disorder, generate better health conditions among the population who may even ignore that they suffer or are developing the disorder, and ideally, ensure that everyone has equal opportunities to receive the support they need. Finally, public prevention policies should allow coordination between different sectors, such as quality psychological care, education, and employment, to address the various aspects that influence the mental health of the people targeted by the programs. The review of the theoretical and technical characteristics of evidence-based psychotherapies that have shown effectiveness in BPD treatment could favor the recognition of social, environmental, or even cultural factors that have a higher impact on people who suffer from this disorder, contributing to the development of prevention programs focused on the condition which is inserted in a specific space and time.[19,22]

If we do not consider the situations raised, various problems could arise regarding the disorder treatment, where implementing uninformed interventions could lead to untimely diagnoses, without adherence to firm and inaccurate criteria. Patients could be treated through ineffective methods to reduce symptoms and conflict resolution. Likewise, the use of unproven treatments could continue with the results of dropout and poor treatment adherence, and above all, patients could be subjected to unnecessary risks in a psychopathology whose most serious effects include risky behaviors, self-harm, and suicide attempts.

DIAGNOSTIC PARTICULARITIES OF BPD

According to the differential diagnostic categories presented in the DSM-5, it is essential to meet at least five of the nine criteria considered to diagnose BPD. It refers to a nosological entity with a large number of possible combinations.[1] The above consideration raises the unusual possibility of finding two patients diagnosed with the disorder with a single symptom in common. Clinical considerations are not limited to the presentation of symptomatology of interrelation but also intra-symptoms subject so that there may be predominance of one type of symptom over another according to different variables of the subject such as age and life cycle or ability to socialize and isolation, as well as a difference in objective and observable evaluation symptoms from those of a subjective nature.

It is important to mention that both the DSM-5[1] and the ICD-10[16] do not take into account the degree or hierarchy where the symptoms of BPD are present, so there would not be any central symptomatology that could be immovable for making the diagnosis.[1,3,21,22] The currently approved approach to personality disorders contained in Section II of DSM-5 is unchanged from DSM-IV, except that they have been removed from the former Axis II of DSM-IV and included in the central classification of disorders. However, the classification of these disorders has been expanded by presenting in Section III an alternative model, called hybrid for subsequent studies[23], which aims to resolve the deficiencies posed by the current diagnostic model of personality disorders. The justification for this is that these disorders constitute an extreme version of the personality traits existing in each person. From this alternative approach, personality disorders are characterized by damage to their functioning (areas of identity, self-direction, empathy, and intimacy) and by their present pathological factors (negative affectivity, detachment, antagonism, disinhibition, and psychoticism). Diagnostic categories derived from this model include only antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal personality disorders.[1,23,24]

Prevalence

According to the World Health Organization (WHO)[25] and registered prevalence studies of borderline personality disorder in primary care databases, the prevalence rate of BPD is considered high, estimated at approximate 2 to 4% of the world population.[26] The figures reported in 2023 by the Ministry of Health in Mexico[14] indicate that it affects 10% of psychiatric outpatients and 15-20% of patients admitted to a psychiatric institution. Statistically, it is the most frequent personality disorder in the world.[1] This disorder begins its symptomatic manifestations in adolescence and is mostly diagnosed in adulthood.[22,26]

Studies on the prevalence of the disorder indicate that between 76 and 80% of cases occur in women and it is diagnosed at ages between 19 and 34 years.[1,14,22,26] It is relevant to note that patients with BPD frequently use health services[15,27], so the importance of having trained personnel and effective diagnostic and treatment means is evident.

Regarding the symptomatic variability and the high level of comorbidity mentioned, about 75% of patients diagnosed with BPD present some other mental disorder, the presence of depressive disorders, anxiety, drug addiction, eating disorders and paranoid symptoms.[1,19,25] On the other hand, the incidence (75%) of subjects with BPD who meet diagnostic criteria for another Personality Disorder is very high[28,29], also finding coincidence with pathologies from different Clusters (DSM-5 defines Cluster as: Certain groupings of personality disorders[1]). Between 30 and 38% have Cluster A personality disorders, mainly Paranoid Personality Disorder and approximately 40%

meet criteria for Cluster B Disorders: Antisocial Personality Disorder and Histrionic Personality Disorder. Finally, it has also been found between 20 and 40% coincidence of symptoms and overlap with Cluster C disorders, such as Avoidance Personality Disorder.[29,30]

Considering BPD as a severe disorder is understood by the high degree of subjective suffering it causes in patients, the social dysfunction it causes and the inability of emotional management that distinguishes it, affecting various spheres of life, not only to people suffering from the disorder but also to those with whom he shares his daily life. The disorder stands out as the only syndrome, where the diagnostic criteria include suicidal, parasuicidal, and autolytic behaviors. The estimate of suicides and suicide attacks in these patients is high, reaching between 4 and 10%, characterizing BPD as a high-risk psychopathology.[29-31]

SPECIFIC TREATMENTS AND THERAPEUTIC DIFFICULTIES

According to the above, we can understand the diagnostic difficulty of the disorder, both in the differential aspect and in its delimitation. However, this is not the only obstacle to consider for the clinical approach in patients with BPD since we also encounter difficulties in establishing an effective treatment for the disorder, especially making informed therapeutic decisions can be the biggest challenge. The treatment choice cannot be limited to the sole consideration of symptom remission or reduction, as we must take into account in this regard the difficulties derived from the functioning of the Limited Organization itself[9,12,31] aspects such as the high dropout rate, therapeutic non-compliance, the patient's emotional instability, dichotomous thinking and irritability, as well as the patient's failures in coping and assimilation skills. On the other hand, according to the characteristics of patients with BPD, frequent injuries, self-harm, intoxication with substances, and the highest level of risk, suicide attempts, which are not rare in the disorder, so sometimes the need to use emergency medical services is common or constant.[15] This can also translate into a high institutional cost and obvious difficulties for their psychological care.[16]

Psychotherapy is been used since the beginning of the clinic for the treatment of mental disorders. It has also proven the effectiveness of its interventions, as stated in the Resolution of the APA regarding the efficiency of psychotherapy in the treatment of mental illness.[17-19]

Although BPD has been included in diagnostic manuals since 1980[32], it is only in recent years that research has provided evidence on the efficacy of specific psychotherapies for the treatment of BPD, four of which stand out:, two cognitive-behavioral: Dialectical Behavioral Therapy and Schema Therapy, and two with a psychodynamic approach: Transference-focused Psychotherapy and Mentalization-based Therapy.[2] Likewise, it is relevant to understand comprehensively the psychological, biological, and social factors that may contribute to solving problems about the efficacy of BPD treatments.

The need for studies that address biomedical and psychosocial aspects to identify the elements to be considered in the efficacy of treatments becomes more relevant according to the multidimensional nature of BPD since being a complex disorder affects multiple areas of a person's life.[33] To comprehensively understand the nature and treatment of this disorder, it is essential to consider these aspects since biological, psychological and social factors can interact in complex and specific ways in each case, which makes the integrative approach necessary to address the individual needs of patients; on the other hand, effective BPD treatments involve addressing not only psychological symptoms, such as intense emotions and instability in relationships, but also biological factors, such as possible neurological or genetic irregularities, and social factors such as family dynamics and community support[12]. Finally, to determine the efficacy of treatments, it is necessary to precisely evaluate considering all aspects of the disorder and its interactions. This involves measuring clinical outcomes, and assessing the quality of life, social functioning, and other relevant factors.

Below is a compilation of studies that will allow us to characterize the theoretical and technical elements of evidence-based psychotherapies that have demonstrated effectiveness in treating BPD. This way, we will be able to account for the criteria with which diagnostic and therapeutic strategies develop in an informed manner. On the other hand, we will see the main challenges to consider and the scientific gaps that could arise in studying the effectiveness of treatments for this personality disorder.[9,15-16]

SPECIALIZED TREATMENT PSYCHOTHERAPIES FOR BPD

The characteristics of some specific psychotherapies treating BPD are selected and analyzed whether they treat it in a general way or aimed at reducing symptoms, considering those treatments that have shown higher evidence of effectiveness in different studies, including Randomized clinical trials, systematically reviewed and meta-analysis[4-6,8-9,16,34-39], according to this, the following treatments are differentiated:

- Dialectical Behavioral Therapy (DBT)
- Schema-Centered Therapy (SCT)
- Transfer Focused Psychotherapy (TFP)
- Mentalization-based psychotherapy (MBP)

Most of these approaches require specialization and offer different ways of understanding BPD. Therefore posing different formulations and different mechanisms by which recovery is possible. Mental health professionals face the challenge of the degree of specialization and clinical resources required by these in their empirically validated procedural forms, briefly described below.

Dialectical Behavioral Therapy (DBT)

Dialectical Behavioral Therapy is a third-generation directive psychotherapy that combines approaches of cognitive behavioral therapies, Zen philosophy, and Buddhism, integrating the latter concepts of mindfulness, values of being, and acceptance of suffering.[40] The therapeutic program includes four work guidelines handled through a therapeutic team: 1) individual psychotherapy, 2) group training in skills, 3) crisis calls, and 4) regular monitoring meetings.

According to May et al.[41], the fundamental goal of treatment is for the patient to incorporate skills that allow him to regulate his emotions and behavior. It requires both the patient and the therapist to adhere to a discipline that facilitates the achievement of goals. However, when it comes to patients with BPD, it can be complicated as frequent crises and intolerance to discomfort make it difficult for the patient to concentrate on learning, and the therapist must postpone the session plan to attend to the current uneasiness and suffering. Because of this, treatment is divided into two main components: 1) Skills-specific training group, 2) Individual therapy, where the individual brings to light the skills learned and where they can attend and respond to the crises of the moment, as well as other behaviors that interfere with the course of treatment.[42] These complement with 3) Crisis telephone service, in which the therapist should pay attention to not making unwarranted use of the tool since patients with BPD are often extremely demanding of the therapist's time and may want to use the resource as a substitute for the therapy session and finally 4) Supervision, carried out among the therapists involved to prevent possible situations of risk and to propose solutions to the problems of the group in general and of each case in particular, in the same way supervision will have the function of preventing therapists from engaging affectively with any group or patient and losing neutrality.[42]

In summary, the main advantage of using DBT for the treatment of Borderline Personality Disorder lies in its integrative and holistic approach that addresses multiple areas of the person's life. Some of its key advantages include:

- **Proven Efficacy:** It is proven that it is effective in numerous clinical studies for treating BPD, helping to reduce self-injurious behaviors, impulsivity, and relationship problems, and improving patients' quality of life.
- **Structured, goal-oriented approach:** Uses a structured therapeutic framework that focuses on specific goals, such as emotional regulation, distress tolerance, and interpersonal skills. It provides patients with a sense of direction and progress in their treatment.
- **Practical coping strategies:** Teaches patients practical coping skills to handle difficult situations, including acceptance and commitment therapy, emotional regulation, problem-solving, and distress tolerance.
- **Emphasis on the therapeutic relationship:** The relationship between therapist and patient is fundamental. Therapists take a compassionate and validating approach, which helps establish a close therapeutic relationship and foster collaboration in treatment.
- **Integration of acceptance and change:** Combines acceptance and change strategies, recognizing the importance of accepting present experiences while working to change problematic behaviors and improve quality of life.

Schema-Centered Therapy (SCT)[43]

Also known as Cognitive-Behavioral Schema Therapy (CBST), it is a form of psychotherapy that focuses on addressing maladaptive and persistent patterns of thoughts, emotions, and behaviors, known as "schemas".[43] These schemes are deeply rooted and dysfunctional cognitive structures that develop during childhood and can have a significant impact on adult life, affecting how a person perceives and responds to itself, to others and the world in general.[44]

SCT combines cognitive, behavioral, and psychodynamic therapy elements to help individuals identify and modify dysfunctional patterns, promoting deep and lasting change.

According to Bach B. and Bernstein D.[45] Schema-Centered Therapy has proven effective for a variety of disorders, including BPD and other personality disorders, as well as for mood disorders, anxiety disorders, and other mental health problems. It follows a therapeutic structure that adapts to the individual needs of the client and the nature of its dysfunctional schemes.

Schemes refer to deeply rooted and relatively stable patterns of thoughts, emotions, and beliefs that develop during childhood and affect how a person perceives and experiences the world. These schemes are underlying cognitive structures that influence how a person processes information and relates to others.[45]

Schemes form in response to significant early experiences, such as interactions with parents or caregivers, traumatic events, or dysfunctional relationships in childhood. These experiences shape the core beliefs about oneself, others, and the world. Schemes can be both positive and negative, but in the context of Schema-Centered Therapy, they focus on those that are dysfunctional and can cause significant difficulties in a person's life.[46]

The therapeutic objectives of Schema-Centered Therapy focus on addressing dysfunctional patterns of thoughts, emotions, and behaviors associated with schemas, aiming to promote significant cognitive and emotional change.[43]

In summary, the main advantage of using SCT for treating Borderline Personality Disorder is its focus on resolving the early maladaptive schemas that underlie BPD and other personality disorders. Some of the key benefits include:

- **Identifying and Addressing Dysfunctional Schemas:** Focuses on identifying dysfunctional schemas. These are ingrained patterns of thinking and behavior that develop early in life and contribute to BPD symptoms. By addressing these schemas, therapy can help individuals understand and change patterns that cause distress and make daily functioning difficult.
- **Integration of multiple therapeutic approaches:** Combines cognitive-behavioral, interpersonal, and experiential therapy elements to address dysfunctional schemas from different

angles. It enables a comprehensive therapeutic approach that addresses both the cognitive and emotional aspects of BPD.

- **Focus on early experiences:** Recognizes the influence of early experiences, especially traumatic or negative experiences, on developing dysfunctional schemas. By exploring and processing these experiences, therapy can help individuals understand how past experiences impact their current lives and develop strategies to overcome them.
- **Coping Skills Development:** Teaches individuals adaptive coping skills to manage the emotional and situational triggers associated with BPD. These may include emotional regulation techniques, problem solving, and improving interpersonal skills.
- **Promoting Self-Reflection and Lasting Change:** By working to identify and change dysfunctional schemas, therapists promote lasting change in the way individuals with BPD relate to themselves and others. It can lead to higher emotional stability, healthier relationships, and above all, a better quality of life.

Transference Focused Psychotherapy (TFP)[10]

This is a nondirective therapy that combines the psychodynamic approach with structured procedures, setting limits and attention to the secondary benefit of the disease; it is a manual and evidence-based procedure developed by the psychoanalyst Otto Kernberg.[2,47] Treatment is designed to enhance the patient's ability to experience themselves and see others realistically and coherently as integrated individuals, and to reduce the need to use defenses that weaken the structure of the self and impoverish its repertoire of available answers.[7] It analyzes the components of each transference disposition manifested in the form of dyads, which always include a representation of the self, a representation of the object and an affection that unites them.[10]

The therapeutic program consists of individual psychotherapy sequenced in three phases, developed by a psychotherapist. 1) Initial phase: formulation and establishment of total activated relationships in the patient's life. 2) Intermediate phase: observation through the current transfer relationship, the exchange of corresponding roles between patient and therapist, and 3) Advanced phase: integration and interpretive connection of positive and negative dissociated transfers, of the reflection in the transfer of idealized and persecutory relationships. Psychotherapy is complemented by case supervision led by a therapist expert in TFP to evaluate the development of the therapeutic process, prevent potential difficulties and preserve neutrality in the therapist-patient relationship through countertransference analysis.[7,10]

The central goal of the treatment will be to integrate partial representations of the self and the object, based on the supposition that the dissociated internal object relations acquire their primitive nature by virtue of a dissociative act, that completely separates aggression from love, creating relationships either completely idealized or persecutory of himself and others; The analysis of these defensive mechanisms that keep this cleavage, provides integration.[48]

According to Yeomans et.al.[10], the therapeutic action focuses on exploring and managing negative and positive transfer. Patients with BPD present the following characteristics. They develop persistent patterns of emotional instability, impulsive behavior, chaotic interpersonal relationships, and a distorted self-image. These situations are projected and explored through the transfer relationship with the therapist.

Transference Focused psychotherapy develops from 4 strategies[10,48]

- Defining dominant object relations
- Observing and interpreting role reversal
- Observe and interpret links between dyads that defend each other.
- Develop in the patient the ability to live and experience more stable relationships.

Dyads are psychic units formed by partial representations of self and the other. They are paired and united by affection. Internal representational systems include opposite dyads, although one of the opposite terms may be closer to consciousness than another; this difficulty promotes excision.[7,10] This mechanism is not only the strong contrast between representations of a good self and a wrong object in the same dyad but, fundamentally, the unbridgeable gap between dyads fully invested with negative affections of hatred and others invested with positive, loving affections.[10] These dyads coexist, but they dissociate from each other and this dissociation has the defensive purpose of protecting each dyad from pollution or destruction by another.[41,48,49]

They are designed to enhance patients' ability to experience themselves and see others realistically and coherently, as integrated individuals, and to reduce the need to use defenses that weaken the structure of the self and impoverish its repertoire of available answers. As a result, the patients are expected to develop a growing ability to control his impulses, tolerate anxiety, modulate affections, sublimate their instinctive needs, develop stable, satisfying interpersonal relationships and experience intimacy and love.[10,49]

In summary, the main advantage of using TFP for treating Borderline Personality Disorder lies in its focus on the therapeutic relationship and the in-depth exploration of the patient's dysfunctional relationship patterns. Some of the main benefits of PFT include:

- **Exploring the therapeutic relationship:** Uses the relationship between patient and therapist as a primary therapeutic tool. The focus is on how the patient's relationship patterns manifest within the therapeutic relationship, providing opportunities to understand and modify these patterns.
- **Deep work on transference and countertransference:** Focuses on transference, which are the unconscious feelings and attitudes that the patient projects onto the therapist, as well as countertransference, which are the therapist's feelings and

reactions toward the patient. The underlying conflicts can be identified and worked through by exploring these dynamics..

- **Integration of psychoanalytic and object relationship theory:** Integrates principles of psychoanalytic and object relationship theory to understand the patient's relationship patterns and their impact on their psychological functioning. It provides a comprehensive framework for understanding and change.
- **Promotion of reflection and insight:** It promotes reflection and insight into the patient's relationship patterns and how these may be related to their emotional and behavioral difficulties by exploring transference and countertransference.
- **Developing Healthier Relationships:** By working on the therapeutic relationship and dysfunctional relationship patterns, you help the patient develop healthier relationships outside of therapy, which can improve their interpersonal functioning and overall well-being.

Mentalization-Based Therapy (MBT)

Mentalization-based psychotherapy, described by Bateman and Fonagy[50] and Bateman et al.,[51] is the therapeutic approach that focuses on developing and improving a person's ability to mentalize. Mentalization refers to the ability to understand and attribute thoughts, feelings, desires, and intentions to oneself and others, which allows one to understand one's behavior and that of others from a psychological perspective.[50]

This therapeutic approach has its roots in attachment theory and psychodynamic theories. It is based on the idea that mentalization is an essential skill for healthy psychological functioning and for establishing satisfactory interpersonal relationships.[50]

Mentalization-based therapy is usually composed of 3 main phases divided over several sessions:

1) The Evaluation process in an individual format,

2) Sessions of psychoeducation in a group format and

3) Sessions in an individual format with each of the patients who make up the group.[8]

Mentalization aims to understand the close relationship between people's behaviors concerning these mental states. On the other hand, mentalization is very important for the self-regulation of each person and also to achieve close relationships with other people or intimate in a healthy and constructive way.[52] It should be noted that mentalization is a capacity that has different dimensions, among which we can find the following: cognitive-affective, implicit-explicit, self - the other, internal - external. When the balance is unbalanced in the direction of one of these opposite poles, different problems could occur, as is usually characteristic in some psychopathologies.[50-52]

The main objective of mentalization-based psychotherapy is to improve the person's ability to mentalize, which implies developing a greater awareness and understanding of one's mental state and others. By enhancing the ability to raise awareness, it seeks to facilitate positive changes in behavior, interpersonal relationships, and emotional regulation.[52]

In summary, the advantages of using MBT for treating Borderline Personality Disorder lie in its focus on improving mentalization skills or the ability to understand and attribute thoughts, feelings, desires, and motivations to oneself and others. Some of the main benefits of MBT include:

- **Promoting self-reflection:** Encourages self-reflection and awareness of thoughts and feelings It can help people with BPD better understand their internal experiences and make more informed decisions about how to respond to them.
- **Development of interpersonal skills:** By improving the ability to mentalize, you can improve the interpersonal skills of people with BPD, helping them better understand others' perspectives, empathize, and relate more effectively.
- **Reducing impulsivity and dissociation:** May help reduce impulsivity and dissociation by encouraging greater awareness and understanding of one's internal experiences, which can help people better regulate their emotions and make more conscious decisions.
- **Improved interpersonal relationships:** Promoting a deeper understanding of one's own experiences and those of others, may enhance the quality of interpersonal relationships for people with BPD by reducing misunderstandings and conflicts.
- **Here-and-now focus:** Focuses on the present moment and current interpersonal experiences, which can help people with BPD develop greater awareness and ability to handle difficult situations at the moment.

EFFECTIVENESS OF EVIDENCE-BASED PSYCHOTHERAPY

Stone M.[33] performed a documentary and theoretical review of the most effective therapeutic approaches for treating BPD to compare its approach and treatment strategies. He stated that although the different therapeutic approaches differ in several points, they converge unanimously in treating the disorder. Evidence-based approaches show significant improvements in all items without evidence of objective superiority. [4] The reason given for the previous statement is based on the general interest of the different treatments to hierarchically address the objectives of the specific treatment for BPD, showing improvements in the main areas of care for the disorder, regardless of whether any of the four models are applied[33]:

- Make sure suicidality is explored and adequately dealt with.
- Deal promptly with the patient's threat to interrupt treatment prematurely.
- Inquire about and treat any severe non-suicidal symptoms.
- Be alert to any signs of gross withholding of important information, any signs of dishonesty, or antisocial tendencies.
- If the foregoing tasks are taken care of, attend to less disruptive symptoms that may be present.
- Focus on personality traits that cause significant trouble at work or interpersonal relationships.
- Focus on less disruptive personality traits, including those more troublesome to the patient.

- Focus on long-range occupational, educational, and interpersonal goals; appropriateness of partner choices and attitudes toward family members.

Sollerberger[9] reviewed the theoretical, practical, and training elements of the four specific BPD treatments (TFP, DBT, MBT and SCT) to discuss and contrast their similarities and differences as intervention methods. It proposes that developing differential indication criteria for the various treatments may lead to further BPD therapy improvement. To this end, he reviews the theoretical and methodological principles of four different approaches to BPD treatment. The four approaches have shown effectiveness in BPD treatment. However, research is needed to maintain long-term results, concluding that, currently, there is no evidence of objective superiority in any of the therapies.

Comparative benefit of treatments

BPD poses high challenges in both clinical practice and psychotherapy for various reasons, including those related to its evaluation and diagnosis, its complexity and comorbidity, as well as its management and treatment. In the studies presented, a review of recent years shows the effectiveness of different forms of treatment, noting that there are several BPD approach forms. In general, we can say that the revised forms of intervention have shown efficacy for reducing BPD-related symptoms, regardless of the theoretical optics on which they are based and their operative forms.

The nosological BPD characteristics may be treated by applying the intervention forms presented. However, it is still the evidence-based psychotherapies that have obtained the best results: Dialectic Behavioral Therapy[40-42], Transferential Focused Psychotherapy[47-49], Schema-Centered Therapy[43-46], and Mentalization-Based Therapy[50-52], these psychotherapies showed overall effectiveness in treating BPD and reducing symptoms. It is relevant to consider that according to Stone[34] and Sollerberger[9] evidence-based approaches show significant improvements in all areas of the condition without evidence of objective superiority, if any.

Although the works of Stone[33] and Soldenberg[9] are considered classic research on the effectiveness of psychotherapeutic models, clinical trials, systematic reviews, and meta-analyses that seek to evaluate the different specialized treatments for BPD continue, as evidenced by the writings presented in 2016 by Alarcón[5], in 2022 by Stoffers-Winterling et al.[53]; in 2023 by Crotty et al.[54] and in the same year by Keefe et al.[55]; who confirm that the evaluations carried out do not find solid evidence to suggest that one psychotherapy is more beneficial than another.

Self-harm behaviors, as well as the ability to regulate emotions have been the most commonly used variables for the evaluation of effectiveness in studies, the application of Dialectic Behavioral Therapy[40-42], Transferential Focused Psychotherapy[47-49] Schema-Centered Therapy[43-46] and Mentalization-Based Therapy[50-52,56] independently of the theoretical approach to which they adhere either psychodynamic or cognitive orientation have shown a decrease in the presence of such variables. However, in some cases that used DBT, despite the symptomatological improvement in patients, there was no significant improvement in the patient's quality of life, which could be explained, in part, by the fact that both types of treatment do not consider the resolution of the underlying conflict.[5,9,39,47,57]

According to the last, the TFP proposes as one of its main objectives to address the conflict underlying the symptoms through therapeutic work focused on interpersonal relationships and transference. TFP, based on psychoanalytic theory, focuses on helping the patient integrate the separate elements of personality that generate dichotomies in the patient's reality, helping to modify the dysfunctional dynamics of their interpersonal relationships.[10]

In the case of BPD, where the symptoms are usually related to difficulties in interpersonal relationships, originating in fearful ages, TFP focuses on exploring and understanding how these difficulties manifest themselves in the therapeutic relationship itself. Through exploration of transference and countertransference, the therapist and patient can better understand problematic relational patterns and work together to modify them.[2,47]

TFP also focuses on helping the patient develop a higher capacity to tolerate emotional ambivalence and frustration and to identify and express their needs more adaptively. And achieve it through exploring the patient's defenses and the work to increase their capacity for introspection and self-reflection, managing to resolve the underlying conflict manifested through the symptoms.[2,10,47]

Comparative studies between different forms of psychotherapy and BPD treatments show general improvement in symptomatology, associated problems and comorbidity of the disorder.[58] The theoretical compatibility between some treatments such as TFP and MBT on the one hand and DBT and SCT on the other, have allowed achieving mixed treatments, combination, and mixed approaches, despite showing favorable results, do not show that these are better than those obtained in separate therapies.

Stone[4] suggests that the effectiveness of treatments should consider the contextual factors around the application of the treatment. He also suggests that their effectiveness, regardless of the type and approach, will depend on both the patient's personality and the therapist and the social and family networks on which they base, as well as the cultural and even socio-economic characteristics where treatments are applied, these factors would operate together with the therapeutic model, each playing a role in the final outcome.

Relating to self-harming behaviors, he addressed a comparative study between DBT and MBT,[59] which showed that both forms of psychotherapy were highly effective. He explains effectiveness as the consideration of attentive listening to the patient's feelings, even those in relation to psychotherapy itself.

These specific to the model forms of work were suitable to address inherent interpersonal relationship situations so that the patient can progress and take advantage of the treatment.

In relation to the recurrence of hospital care either because of BPD symptomatology or the patient's general functioning, the decrease in admissions may result due to treatment effectiveness This variable was observed in the different psychotherapeutic models, Dialectic Behavioral Therapy[40-42,], Transferential Focused Psychotheraphy[47-49] Schema-Centered Therapy,[43-46] and Mentalization Based Therapy;[50-52] they all showed a significant decrease in using medical services, either internment or emergency, without any approach showing greater effectiveness. The same level of equitable effectiveness was noted for all models improving overall functioning, social adjustment and quality of life. Although these did not achieve significant indicators, we could understand it from the fact that the evaluation guidelines can be considered from general parameters without consideration of particular contexts as suggested by Barnicot.[59]

BPD presents various comorbidities with other disorders and pathologies. However, anguish and depression seem to be the most frequent. The emotional distress with which subjects with BPD live provokes subjective discomforts that can lead to different risky behaviors. Therefore, an anxiety decrease represents an improvement in the patient's quality of life. In this factor it has been observed that DBT[60-62] has contributed to its significant decrease. On the other hand, a favorable trend has been found, although not significant in MBT[59,63]. As DBT is a cognitive behavioral therapy, it favors the management of anxiety, providing better strategies before the appearance of distress.

The Therapeutic Alliance is considered very necessary for the effectiveness of psychotherapeutic treatments. However, it is particularly important in BPD due to the high percentage of therapeutic abandonment recorded[57-58]. In this regard, TFP[47] and DBT[40] obtained a solid bond between patient and therapist. According to literature, there is no evidence of this variable in the other models. It is relevant to consider that each approach raises different criteria in relation to the development of the bond, the therapeutic alliance, and the therapy abandonment. In the same way, it would be relevant to conduct more in-depth studies to determine if the abandonments are the result from patients evaluating the subjective benefit of the therapy or if it is an inherent situation attributable to the therapist.[55] We can solve it only by studying a particular follow-up of patients who have abandoned their treatment.

SUMMARY OF IMPORTANT ASPECTS

This brief approach does not intend to establish a hierarchy of treatments concerning their efficacy, and is not possible anyway because they all reported similar results regarding treatment efficacy, Stone[34] and Sollerberger[9]. Above all, it aims to have the information necessary to make informed decisions regarding the different specific treatments for BPD.[2]

The results and guidelines herein presented may be used for future research, ranging from symptomatological elements to therapeutic, comparative treatment and mixed intervention proposals.[16, 64] The evaluation of each therapeutic approach's particular elements and each study enables the integration and combination of factors[16], so that there is the possibility of enriching the possible interventions and making them specific in each case based on empirical evidence. Possibly eclectic treatments for BPD management can be seen in a future.[6 53-54,57]

The review of clinical studies and systematic reviews that have evaluated evidence-based psychotherapies for BPD allows us to observe the significant advantages they present, demonstrating their effectiveness as specialized treatments, highlighting the coincidence they present in the following areas:

- **Demonstrated Effectiveness:** These are therapies based on solid research supporting their effectiveness in BPD treatment. This means that there is scientific evidence to support its ability to help people suffering from this disorder.
- **Structured approach:** Evidence-based therapies offer a clear and structured approach, providing a solid framework for treatment. This can be especially beneficial for individuals with BPD, who often struggle with emotional stability and regulation.
- **Skills Development:** These therapies focus on teaching specific skills to manage BPD symptoms, such as emotional regulation, problem-solving, and interpersonal skills.
- **Adaptability:** Evidence-based therapies can be personalized to address the specific symptoms and unique circumstances of each person with BPD, making them adaptable to individual needs.
- **Long-term guidance:** Although improvements may take time, evidence-based therapies aim to provide long-term benefits for those who receive them. This may be especially important for BPD, which often requires a long-term, ongoing approach to effective treatment and management.

Finally, it is important to point out the limitations inherent in this study. The lack of methodological homogeneity in the results reported by the different psychotherapies deserves special attention, so it is also important to note that there is not yet a homogenized or standardized evaluation instrumentation for evaluating the BPD treatments' effectiveness. This also applies to the training of psychotherapists and the duration of treatments. However, it is complex to compare the treatment's effectiveness through the diversity of evaluation instruments used to measure the same variable. This lack of homogeneity could extend to effectiveness evaluation in many or perhaps all psychotherapeutic treatments and theoretical approaches.[53-54]

It is also important to note that there are no studies on applying these psychotherapies in Spanish-speaking populations. This becomes important when considering if the psychological evaluation instruments should be standardized and validated for specific populations with greater importance, studies evaluating the contextual situations of Spanish-speaking populations or

populations with cultural determinants that confirm the efficacy of treatments within this specific population.[28,48,53]

The abovementioned would facilitate a more effective comparison of treatments; above all, it would allow us to understand how cultural variables influence the development of psychotherapy applied to BPD-specific treatments. Finally, it is also important to point out the need to create effective public health policies, which shall be based on the results obtained from the different BPD therapeutic interventions If in their rehabilitative aspect, the approaches have yielded positive results,, it will be necessary to continue researching to design protocols and manuals focused on preventing this disorder and the development of more serious symptoms, and continue to make efforts in the area of health promotion, facing the enormous challenges this represents concerning mental health.

CONCLUSION

Advancements in evidence-based psychotherapies for BPD treatment currently offer positive outcomes in areas such as emotional regulation, interpersonal, and problem-solving skills. However, these treatments present significant limitations and challenges, as more rigorous and contextualized research is needed to understand the effectiveness of psychotherapies. This research should consider the cultural contexts of the population and the diversity of assessment instruments. Notably, there is currently no validated assessment instrument in Latin America. Despite these challenges, the future looks promising as elements from different therapeutic approaches are integrated by providing eclectic therapies. Additionally, it is crucial to create effective public policies to improve BPD management and promote mental health.

ABBREVIATIONS

APA	American Psychological Association
BPD	Borderline Personality Disorder
DSM-III	Manual of Mental and Statistical Disorders 3rd version
DSM-5	Manual of Mental and Statistical Disorders 5th version
DTB	Dialectical Behavior Therapy
ICD-10	International Classification of Diseases 10th Revision
ICD-11	International Classification of Diseases 11th Revision
MTB	Mentalization-Based Therapy
SCT	Schema – Centered Therapy
TFP	Transference-Focused Psychotherapy
WHO	World Health Organization

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