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Virtual self-help groups for patients with borderline personality disorder (BPD): theoretical review

Grupos virtuales de autoayuda para pacientes con trastorno límite de la personalidad (TLP): revisión teórica

Verónica Islas León[a]

Abstract:

BPD is a pathology that affects more to female population, which, prevents the full development of the sufferer and their close relatives. It is a disorder that has as a peculiarity the emotional instability, with overflowing behavior patterns. This type of patients requires special and continuous attention for long periods of time. It has been stipulated an approximate of 6 months and up to 4 years as the case may be. Since 2020 many of these patients are confined to their homes, without the possibility of continuing their treatment. In the understanding that these patients lack functional structures, after a certain time of stress and uncertainty, these patients usually fall into crisis being vital the continuous emotional support. Given the COVID-19 crisis and the needs of these types of patients, it is intended to explore the feasibility of virtual support groups in particular for this disorder.

Keywords:

TLP, self-help groups, online interventions

Resumen:

El TLP es una patología que afecta mas a población femenina, que impide un desarrollo pleno de quien la padece y de sus familiares cercanos. Es un trastorno que tiene como peculiaridad la inestabilidad emocional, con patrones de conducta desbordantes. Este tipo de pacientes requieren de atención especial y continua durante largas temporadas. Se ha estipulado un aproximado de 6 meses y hasta 4 años según sea el caso. Desde el año 2020 muchos de estos pacientes están confinados a sus casas, sin la posibilidad de continuar un tratamiento. En el entendido que estos pacientes carecen de estructuras funcionales, después de cierto tiempo de estrés e incertidumbre, estos pacientes suelen caer en crisis siendo vital el respaldo emocional continuo. Dada la crisis por COVID 19 y las necesidades de este tipo de pacientes, la intención fue explorar la viabilidad de grupos de apoyo virtual en particular para este trastorno.

***Palabras Clave**:*

TLP, grupos de auto ayuda, intervenciones en línea

INTRODUCTION

BPD borderline personality disorder is described as a disorder of emotional instability currently the multiple social difficulties to be faced and the limited capacity of these patients to face the problems (Rodríguez, 2016). It forces health professionals to look for treatments and strategies that adapt to the new situations typical of BPD.

From the first time BPD was described in DSM-III and to date, certain characteristics stand out in its description, highlighting phrases such as "difficult diagnosis, difficult treatment, difficult follow-up, tendency to abandon, etc." (García, 2007; García et al. 2010, Salgado, 2014; Caballo & Camacho, 2020) among other authors in different years. In contrast, treatment approaches place particular emphasis on transference and countertransference between patients and therapists. Proposing that therapists must have a specialization to care for these patients.

According to Aguero et al. (2014), BPD patients lack coping skills and have difficulties with stress management. Proposing that therapies for this type of patient should focus on the acquisition of these skills. Some therapeutic proposals mention support groups alongside their therapeutic treatment (with different emphases).

Since 2020, in the face of the COVID 19 pandemic crisis, patients saw limited continuity with their face-to-face therapeutic treatments, as well as group meetings, therapists concerned about the well-being of BPD patients see the use of

a Corresponding author, *Instituto de Posgrado en Psicoterapia Cognitivo Conductual (IPPCC)*, https://orcid.org/0000-0001-7515-7780, Email: psicologaislas1112@gmail.com

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electronic networks as an option for treatments of continuity (Vergés, 2021).

Taking into account that the new technological conditions offer us virtual platforms that are easily accessible at any time of the day, the objective of this article is to explore the feasibility of creating virtual therapeutic support groups among people who experience similar situations typical of specific psychological conditions such as the TLP.

METHOD

For the present work, an exploratory, descriptive analysis of BPD and its treatment was carried out, focusing our attention on electronic publications that expose a historical point of view, outpatient treatments in BPD care, current analysis of self-help groups, new dispositions of the exercise of psychology in the face of the COVID 19 pandemic, giving priority to articles published in the last 21 years. Different platforms such as GOOGLE ACADEMIC, Redalyc, Scielo, and other electronic media were used. A review was also made of clinical practice guidelines on BPD published and posted online that included complementary treatments.

RESULTS

Although BPD is constantly studied and detailed in multiple publications, past and recent, it is also a pathology that requires many skills for its diagnosis and treatment, and it is essential to recognize comorbidities with other pathologies. Within the different articles found, special emphasis is placed on the risk of suicide, treatment abandonment, self-medication, substance use, and treatment problems since these patients usually generate transference and countertransference with their therapists, biasing the objectivity of the treatment. Publications were also found that explore the benefits for these patients of achieving identification with other peers and how gratifying it is to listen and feel listened to. Some treatments include group therapeutic processes as part of a comprehensive treatment.

Borderline Personality Disorder

Borderline Personality Disorder (BPD) in the Diagnostic and Statistical Manual of Mental Disorders (DSM 5) is defined as a dominant pattern of instability in interpersonal relationships, self-image and effects, and intense impulsivity, which begins in the early stages of adulthood and is present in various contexts and is manifested by five (or more) of the following symptoms (American Psychiatric Association [APA], 2013):

1. Desperate efforts to avoid real or imagined helplessness.
2. Pattern of unstable and intense interpersonal relationships characterized by an alternation between the extremes of idealization and devaluation.
3. Identity disturbance: intense and persistent instability of self-image and sense of self.
4. Impulsiveness in two or more areas that are potentially self-injurious (eg, spending, sex, drugs, reckless driving, binge eating).
5. Recurrent suicidal behavior, attitude, threats, or self-mutilating behavior.
6. Affective instability due to marked mood reactivity (eg, intense episodes of dysphoria, irritability, or anxiety that usually last a few hours and rarely more than a few days).
7. Chronic feeling of emptiness.
8. Inappropriate and intense anger, or difficulty controlling anger (eg, frequent display of temper, constant anger, recurrent physical fights).
9. Transient stress-related paranoid ideas or severe dissociative symptoms.

The International Code of Diseases (ICD 10), prepared by the World Health Organization, identifies BPD as Borderline Emotional Instability Disorder.

BPD Historical Review

In 1684, Bonet described a syndrome, uniting impulsiveness and unstable moods, naming it “folie maniaco-melancolique” (Million & Davis, 1998). In 1810 Pinel was the first to record in writing symptoms compatible with what we know today as BPD (García et al., 2010). Being until 1921 that Kraepelin indicated the main diagnostic criteria: impulsiveness, instability of affectivity and interpersonal relationships, intense and inappropriate anger, and self-injurious acts (Millón & Davis, 1998; Kretschmer, 1925, as cited in Millón, 1989), considering that it is a cycloid-schizoid temperament and specifies the predominance of infantile aggression, primitive narcissism and with serious alterations of the superego (Helmich et al., 2017). Later Adolf Stern (1938), for the first time, described the diagnostic criteria, describing it as the border group. Over the years, they have been comparing and distinguishing it from other pathologies such as schizoid disorder while defining it as a disorder with particular and specific characteristics. By 1950, Schneider described him as a "labile" personality. Since then, changes have been made in the concept, using the term "borderline" to describe pathological character forms (Millón & Davis, 1998).

It is in the DSM-III that it is included as an independent pathology (Helmich et al., 2017); borderline personality disorder is included for the first time; this term describes a very important population that had not previously been described; however, Some psychiatrists question the term "borderline", while describing the evolution of the term and the multiple controversies that were seen in comparison with other disorders. Highlighting some of its characteristics such as dependency, histrionics, change in mood from a state of euphoria to a state of discouragement and self-destruction, highlighting attitudes of self-condemnation, as well as feelings of shame and emptiness, without overlooking the tendency of negative thoughts (Million & Davis, 1998).

BPD prevalence

Garcia et al. (2010) mentions that the prevalence of this disorder ranges between 1-2% in outpatients. At the same time, the population of hospitalized patients varies between 11 and 32% in a psychiatric hospital in Spain.

Aragonese et al. (2013), on the other hand, expose a prevalence between 1.4% and 5.9% in Catalonia, very similar to what is exposed in an article published by the University of Seville (Agüero et al., 2014) that mentions the prevalence calculated approximately in 2 % of the general population that meets the diagnostic criteria.

In Argentina (Salgado, 2014), it is estimated that this disorder affects between 2% and 6% of the population in a psychiatric hospital in this country. Likewise, Helmich (2017), also in Argentina, estimates the prevalence of this disorder between 2% and 3% of the general population. Like Etchevers et al. (2018), returning to Torgersen (2009), mention that the prevalence in the general population is 2% to 3%.

In 2018, the Mexican health secretary, in a statement, stated that BPD has a prevalence of 1.5% of the population according to data from the Fray Bernardino psychiatric hospital.

However, we must recognize that, in private clinical practice in Mexico, there are no care statistics, thus being a potentially higher estimate not only in Mexico, considering personality characteristics (tendency to abandon treatment and change of therapists).) and the need for attention. It can be estimated that the prevalence is higher considering this lack of information.

Diagnosis

Multiple questionnaires have been developed specifically for the diagnosis of BPD, among which we can find COPE (Coping Orientations to Problems Experienced), which is a standardized instrument for the Spanish population.

On the other hand, Garcia et al. (2010) state that the diagnosis is categorical; that is, it must comply with the certain number of items specified by DSM 5 or ICD 10, as mentioned by several authors applying the clinic. At the same time, it mentions that another way of diagnosing is the dimensional use (model of five major factors, Lively model, Cloninger model, and biopsychosocial model) which, unlike the previous one, allows the degree of symptomatology to be categorized.

As already stated, the diagnosis of BPD is usually made through specific questionnaires and structured and semi-structured interviews following the criteria mentioned in DSM 5 and ICD-10. However, semi-structured interviews allow the evaluator to expand the possibilities of response while the patient tends to expose his situation more widely from his perspective, allowing the analyzer broader management of his emotional states by virtue of open discourse without forgetting or passing by the need for specific questionnaires validated according to the region where we find ourselves (GPC workgroup, 2011).

It is necessary to establish a good differential diagnosis, paying special attention to the comorbidity that BPD may have with other psychological disorders and the moment or type of symptoms that our patient presents at the time of being evaluated (Caballo & Camacho, 2000).

Theories of the origin of BPD

1.- Neurobiological theory: Guendelman et al. (2014) make a detailed analysis of the different studies that tried to find a specific biological factor that could explain BPD, finding that genetic studies showed that 35% of monozygotic twins inherited the disorder. Mosquera et al. (2011) state that genes explain between 40% and 60% of the variability of personality traits.

Despite this, Guendelman et al. (2014) determines that the results are not conclusive, however, they states that BPD patients could have been born with genetic tendencies to create brain systems that are deficient in regulating impulses and affections. And it relates to the results of some studies that expose genetic inheritance as the main determining factor in the production of certain enzymes and sensitivity to them, such as norepinephrine, serotonin, dopamine, among others.

Tajima et al. (2009) present the results of functional imaging studies using different techniques such as MRI, and MRI, finding that only patients diagnosed with BPD present morphological changes that would explain impulsiveness and cognitive defects. They also expose the relationship between brain morphological variations and childhood abuse, areas directly involved in the response and regulation of affective states that at the same time correspond to post-traumatic stress. Regarding the activation of the orbitofrontal cortex, it is also altered in patients diagnosed with BPD compared to patients with other pathologies.

Guendelman et al. (2014) conclude that although all the studies previously exposed are not conclusive or predisposing to the diagnosis of BPD. Currently, and based on all these studies, it is recognized that psychological and social trauma produces morphological changes and changes in brain function, thanks to epigenetic mechanisms and neuroplasticity phenomena that give expression to behaviors typical of BPD. That is to say that they did not achieve the etiopathogenesis of BPD by not verifying that a hereditary factor is a determining propellant of suffering from it, but yes, that certain brain areas are affected by traumatic events, achieving neuromorphic modifications, and this, in turn, provide the risk or vulnerability related to behaviors typical of BPD.

2.- Attachment theory as the origin of BPD.

There are many studies that try to explain the origin of BPD from attachment, as exposed by Mosquera et al. (2009, 2011), where they argue that the environmental development of the individual is part of the waters for the development of BPD and other pathologies.

With the understanding that personality disorders are characterized by mental conditions that show a prolonged pattern of thoughts, feelings, and behaviors. And that these behaviors interfere with the development of this individual's life since it prevents them from developing and performing

favorably in their interpersonal, work, and family relationships (Abarca, 2021).

Attachment, according to Ainsworth and Bell (1970, as cited by Etchevers et al. 2018), establishes that there are three types of attachment characterized by:

Secure attachment implies that the caregiver is attentive, sensitive, and available. In this way, the minor acquires this security in his presence as well as in his absence since it assumes that the minor has acquired the necessary skills to contain the tensions of the caregiver's absence and continue with his activities, having the certainty that the caregiver will return to provide the care and support that was previously established between the two.

Insecure-Avoidant attachment, the minor sees the need to develop survival skills in the presence and absence of his primary caregiver since he does not consider his caregiver as someone willing to provide security and stability or support. It is said that this minor could be kept in a space with attitudes of independent development, while not seeking physical contact with his primary caregiver, while the responses they emitted had a defensive tendency, denying the need for their caregiver and thus avoiding frustrations.

Insecure Attachment – Ambivalent; in this type of attachment, the minors are worried, they do not explore their environment, and they are very anxious. But in the presence of the main caregiver, they are irritable and ambivalent. This was in response to the attitude of the caregiver, who previously had responses of sensitivity, but at other times and without explanation at times they could show little interest. These inconsistencies lead the minor to a state of insecurity.

The minor to a state of insecurity.

Returning, secure attachment to the main caregiver provides coping and stability mechanisms for adult life in the face of traumatic events since they will tend to develop patterns of trust and strength, which patients diagnosed with BPD lack. Attachment theory is proposed as an environmental explanation that contributes to the response learning typical of this disorder. (Mosquera et al. 2011), (Salgado, 2014)

Helminch et al. (2017) mention attachment theory as an intention to explain BPD, taking up what was mentioned by John Bowbly (1989), exposing attachment as a regulator of emotional experience; therefore, BPD may be the result of a failure to establish attachment.

Most people diagnosed with BPD have the feeling of not fitting into the social environment in addition to other characteristics such as a high level of self-deception and inability to listen; depending on the type of attachment these patients have, it can also be a turning point for prognosis of the same, since it also frames the perception they will have of their therapist and the prognosis of their performance in therapy (Caballo & Camacho, 2000).

3.- Trauma as the origin of BPD.

As already mentioned, a trauma in childhood has been considered the turning point to justify BPD. Johnson et al. (1999, as cited in Mosquera et al. 2011) show that people with abuse or neglect documented in childhood were four times more likely to be diagnosed with BPD. Likewise, Zanarini (2000), when reviewing the empirical literature, found that patients diagnosed with BPD reported between 40% and 70% of child sexual abuse compared to other disorders; In addition to this, Graybar and Boutilier (2002) found that between 60 and 80% of people who reported having suffered from violence, sexual abuse, physical and verbal abuse, as well as neglect in their childhood were patients with a BPD diagnosis, other authors such as Golier et al. (2003) also reported high rates of early trauma, that is, 52.8% of patients diagnosed with BPD had a history of childhood trauma. From the foregoing, it can be concluded that mistreatment, physical and psychological abuse, negligent attitudes of caregivers, etc. It is a constant in the history of patients diagnosed with BPD.

The child is understood as a being learning and acquiring skills to face difficulties; let us think that the main caregivers are the first models to follow for this knowledge; if these caregivers do not have sufficient skills to transmit knowledge, the child will be left with these missing that in turn tried to compensate, drawing their own conclusions of response. Now, a traumatic event, whether due to physical or emotional abuse, social situations, etc. It will require adaptations of the child to face this situation; if at the beginning the minor does not have skills, he must respond with the intention of safeguarding his integrity, generating responses of mistrust, aggression, magnified expression of emotions, etc. Physically or chemically modifying the structure of his brain as an adaptive form of learning (dysfunctional-social), to continue with these responses for a long time since they worked for him to face an initial situation. This would explain that the three theories contribute one after the other to the appearance of BPD (Torres et al., 2017).

Treatments

The central theme of this article is online group interventions as a stabilizer against contingency and not as a cure; for this reason, we will focus on outpatient treatments since it is worth mentioning that in extreme cases, the treatment must include hospitalization in a clinic. psychiatric

Along with the therapeutic processes, it must be accompanied by a pharmacological treatment that helps the individual maintain an emotional balance. This pharmacological treatment can usually include SSRIs, antipsychotics, lithium, naltrexone, and Omega-3 fatty acids, taking special care with benzodiazepines since some of the side effects can alter the anxious state of the BPD patient, as indicated by Chavez-León et al. to the. (2006) who coincides with García et al. (2010).

Aware of the affective deficiencies expressed by patients with BPD, the therapist must comply with certain characteristics of emissivity without falling into countertransference phenomena, which compromise the therapeutic process and, therefore, the emotional and dependent state of the same patient (García et al.,

2010; Mosquera et al., 2011). The therapist must be in constant preparation to distinguish these phenomena and have effective support strategies, always with the support of psychiatry for the medication of cases that require it (García, 2007).

The therapies or treatments that have shown the greatest effect in BPD patients are set out below:

Mentalization-Based Treatment (MBT); propose the understanding of oneself and others. Concluding that it reduces suicide attempts, as well as depressive symptoms, self-harm, and suicidal ideation, these improvements were maintained even after five years of patient follow-up (Bateman & Fonagy, 2008, 2010, as cited in Helminch et al., 2017).

Schema-Focused Therapy (SCT); is an integrative therapy that combines elements of cognitive-behavioral schools, attachment theory, Gestalt, constructivism, and dynamic elements. It emerges as a treatment alternative for those patients with chronic disorders considered difficult to treat, including patients with PD (Young, 2013, as cited in Torres et al., 2017).

Dialectical behavior therapy (DBT) focuses on the assumption that BPD patients have poor coping skills. This therapy aims to learn skills divided into four modules (basic awareness skills, interpersonal effectiveness skills, emotional regulation skills, and discomfort tolerance skills) (Linehan, 1993 as cited by Agüero et al., 2014).

Cognitive-behavioral therapy explains personality as a set of thought patterns. CBT works with maladaptive physical, emotional, and cognitive-behavioral responses of learned characters. This therapy focuses its attention on the individual and in the present tense with the intention of combating disruptive thoughts, ensuring that he is the one who designs more adapted speeches (Beck, 1995), (Barria, 2019). García (2007) states that the CBT therapeutic model is indicated for initial treatments of BPD, especially for the control of impulsive behaviors. Its objective is to help the patient maintain their mood and to make the patient aware of their behavioral response to mitigate the effects of abandonment, insufficiency, mistrust, and incompetence. This therapeutic model is limited to a number of specific assignments and is considered a model of short duration.

Group therapy; This therapeutic technique is more effective as long as it is accompanied by individual therapy. Since it offers patients alternatives for their own response to learning from social interaction, the groups must be formed by patients who have similarities in the expression of their symptoms and functionality. Given that in group interventions, the patient will exhibit less resistance and will improve the acceptance of these new response proposals exposed in the group while obtaining the social recognition of the group. (Garcia, 2007).

Online care through self-help groups

The importance of knowing more about this type of patients and proposing other treatments to keep them stable for as long as possible leads us to look for modern alternatives that are available to more people. In addition to this, the limitations that the world has faced since 2020 with the COVID 19 pandemic showed us that we could make use of technological tools that we can exploit for this purpose, for example, the most commercial virtual platforms worldwide.

Verges (2021) describes how psychological intervention through FONO HELP has worked in the context of a pandemic prior to a specific design for remote care. FONO AYUDA assisted a total of 1,093 people, with a total of 6,558 telephone interventions dealing with different problems such as depression, anxiety, stress-related disorders, and suicidal ideation, among others. Leaving as a reflection of the need that arises in this health crisis for psychological care and containment. For this reason, there is a possibility of providing this type of care to a particular pathology such as BPD.

Carrying out a quick review of the number of users in different electronic media, we find that the use of technologies available to many people is the objective; As of January 2021, two billion users were accessing WhatsApp chat on a monthly basis. Instant messaging is an exchange of texts online in real-time with the use of the Internet. Since the advent of smartphones and the subsequent explosion of mobile apps, free or low-cost chat and social messaging apps have proven to be a cost-effective alternative to carrier-based text messaging over SMS. Many messaging applications offer features such as group chats, graphic exchange, video, and even audio messages (Fernández, 2021).

In this understanding, Rubio (2008) explains the beginnings of support groups as movements lacking structure, which over time define dynamics and order, contributing to the specialization of these groups; however, he mentions that excessive specialization limits the ability to address the issue or problem in all its aspects.

Suriá & Beléndez (2009) highlights the popularity that is beginning to stand out on the Internet, searches for support related to health as a way of learning about their condition from the perspective or experience of others in the same condition.

For this, self-help groups have a therapeutic effect since it allows members to communicate their emotions in relation to their problems, remembering that from expression, we can achieve the reinterpretation of stressful or traumatic events, working as well as a therapeutic tool (Garcia, 2007; Suriá & Beléndez, 2009).

García (2017), like Morón (2018), recognize group therapy as an effective technique to treat different problems, which has shown important benefits. Sebastián (2015, as cited in Morón, 2018) mentions that our efforts should be directed to formalize this type of psychological technique, highlighting the benefits that are obtained, such as the recognition and need for belonging of individuals, which in cases of BPD help to the restructuring of people within a social environment.

Gallego et al. (2018), as did García (2017), state that mutual self-help groups are based on learning among participants who share certain characteristics of equality and needs; These individuals will produce learning by managing to connect with

the needs as a group but delimiting certain demographic characteristics (age, sex or problem), this will help the group to be homogeneous in terms of their vision of the situation for which they are gathered.

So self-help groups allow participants the freest and most comfortable expression of their ideas while allowing the anonymity of their secrets or problems. Like the people who participate in these forums, they are forced to reorganize their ideas to express themselves, thus allowing cognitive restructuring, typical of a therapeutic process (Suriá & Beléndez, 2009).

Also, Gallego et al. (2008) emphasize that the interaction between equals must have a previous training process with the intention of homogeneity and thus in some way guarantee that the communication between the members is comparable and enriching.

Rubio (2008) highlights that associations are a versatile resource that provides members with an experience of welcome, harmony, and rapport. And that active participation within them can create a new way of life for its members, supporting a recovery process and a more functional social reintegration. Emphasizing that, by creating these groups, visibility is given to a particular condition and therefore, re-education of the members begins, but also of the people who find out about their existence, starting from the idea that a way to limit compromise social is information.

It should be considered that the self-help group should always have a moderator and filter for the answers issued by the participants, and it should be ensured that aggressive or hostile responses from users towards other participants are avoided, on the understanding that these groups are only for support and collaboration given the impossibility of face-to-face meetings.

DISCUSSION

Highlighting the importance of providing psychological care to BPD patients and the need to receive support and long-term care. Taking into account the current situation in the world affected by COVID 19. Psychological care should be adapted to health provisions in mobility and concurrence (several people do not meet in the same space).

The creation of virtual support groups is proposed, making use of the technology available to society. For those who generally have a mobile device and access to platforms such as WhatsApp, this opens up the possibilities for BPD patients who are in need of psychological support to receive it. Without necessarily requiring moving to an office or support group spaces.

Returning to the therapeutic model that was worked on in Cuba (Castelnuovo et al. cited by PSICO GROUPS WhatsApp, 2020), which recognizes the use of psychological digital platforms as a contribution to society. They conclude that there are pros and cons of these practices; while highlighting the benefits in the face of the health crisis, the results of this practice were favorable for both the patient and the psychologist; patients were more comfortable and open to therapeutic work.

Making it clear that for this proposal, all participants must have previously been in individual therapy, must be in psychiatric treatment and that group treatment is only for outpatient support. The group therapist must maintain a format very similar to the one used in these face-to-face groups. Only adding the variants of the technology and the use of a technological platform, making the modifications that are considered to continue providing psychological containment support.

Perhaps one of the limitations that can be faced is the particular way in which BPD patients perceive information, which may be biased and would be left to the therapist to mediate and regulate the flow of information. It is proposed that the therapist in charge also have individual sessions after the group interventions to assess the possible biases derived from these new strategies.

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