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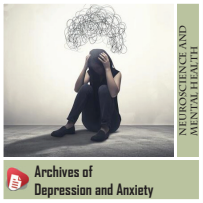

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Review Article

Evidence Psychotherapy Options for Borderline Personality Disorders

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Keywords: Borderline personality disorders; Dialectical behavioural therapy; Mentalization based therapy; Transference focused psychotherapy; General psychiatric management; Integration therapy; EMDR

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Abstract

Borderline Personality Disorder (BPD) is a prevalent and severe condition that affects emotional regulation, interpersonal relationships, and identity. BPD affects 1-2% of the population, mainly women, with high comorbidity, especially post-traumatic stress disorder, and a significant suicide rate. The diagnosis is based on ICD-11 and DSM-5 criteria with functional evaluation and specific traits. Various therapeutic models have shown efficacy in improving the quality of life and reducing self-destructive behaviours in these patients. The Evidence-Based Therapies are Dialectical Behavioural Therapy (DBT), Mentalization-based Therapy (MBT), Transference Focused Psychotherapy (TFP), and General Psychiatric Management (GPM), each with specific approaches and techniques for the treatment of BPD.

Therapies can be combined according to the clinical phase and patient needs, using sequential progressions, technical eclecticism, or synthesis, with a common focus on validation, empathy, and active therapeutic alliance. EMDR is used to treat associated childhood traumas and improve prognosis.

Introduction

Personality disorders represent a pathological extreme in a continuum between adaptive personality and severe desadaptation, and they affect approximately 9% of the population. These disorders usually appear during the first decades of life, generally during adolescence, and frequently concurrent with other psychiatric symptoms as depression or anxiety [1].

Personality has two main components: temperament, which is biological and stable since infancy, and character, which is developed through learning and environmental experiences [2,3]. Among other models to explain personality, Cloninger's dimensional model for personality disorders differentiates persistence and three character dimensions: self-directedness, cooperativeness, and self-transcendence, which influence the behaviour and the adaptation of the people [1,3].

In terms of neurobiological basis, some traits are related to specific neurotransmitters, as serotonin, dopamine, and norepinephrine, related to impulsivity, aggressivity, and novelty seeking. This has relevance for the psychopharmacological treatment [1,3].

Environmental and social factors also have an impact on the development of personality disorders, especially traumatic experiences in infancy, as physical abuse, neglect, abandonment, severe illness of one of the parents, or social adversity. The impact is higher in B group disorders (borderline, narcissistic, histrionic, and antisocial) [2]. Other factors influencing the development of a personality disorder include the attachment model with caregivers, especially the mother [4,5].

The objectives of this work are to discuss the different approaches to the treatment of Borderline Personality Disorders, to present a brief outlook of the strategies with

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efficacy evidence, and to introduce some models to integrate the different strategies to improve not only efficacy but also the possibility of treating more people.

Treatment of Borderline Personality Disorder

Borderline Personality Disorder (BPD) is a condition with a high prevalence and severity, characterized by functional difficulties in interpersonal relations, identity, and affects, and auto-destructive and suicidal behaviour. Although previously the prognosis of BPD was bad, currently there are psychotherapies with evidence-based efficacy that deal with these clinical and social complexities [6,7].

BPD affects 1-2% of the general population, more frequently among women, and has a high rate of comorbidity, overall, with posttraumatic stress disorder. Suicide rate is significant, between 8-10% of affected people will die from suicide [8,9].

Diagnosis is made usually following the ICD-11 and DSM-5 criteria, which include a functional evaluation of personality and five specific traits that help to describe the disorders (*negative affectivity, detachment, antagonism, disinhibition vs. compulsivity, and psychoticism*). Several facets define each personality trait. Among the different personality disorders, the comorbidity is very high [10], which hinders a clear discrimination among categories [1,2,11].

There are four principal psychotherapies with scientific support for the treatment of BPD: Dialectic Behavioural Therapy (DBT), Mentalization-Based Therapy (MBT), Transference Focused Psychotherapy (TFP), and General (or Good) Psychiatric Management (GPM). Also, there are other therapies available that can be useful, as Eye Movement Desensitization and Reprocessing therapy (EMDR), which is used when early trauma is present (12), or Schema-Focused Therapy, based on Cognitive therapy [13].

Each therapy has an approach and specific requirements: DBT combines cognitive-behavioural techniques with emotional regulation skills and mindfulness; MBT emphasizes the awareness of self's and others' mental states; TFP is based on psychoanalysis to improve internal and external object relations; GPM integrates psychodynamic and behavioural models with an approach to the management of interpersonal stress [8].

Personalized medicine is an intuitive concept that can be defined as "the medical approach that uses the specific biological characteristics, environment, needs, and lifestyle of an individual to create ad hoc therapy" [14]. Previously, it has been developed for pharmacotherapy, but the vision is that in the future it would change the clinical processes, overall, with the role of eHealth. In this field, eHealth could facilitate self-report data, access to medical services, reduce costs, and improve prevention. Artificial intelligence (AI) can support medical decision-making, diagnosis, and tailor therapy for people with personality disorders [15]. Psychotherapy approaches influence attitudes towards AI, more positive for cognitive behavioural therapists compared with psychoanalytic and systemic approaches.

Dialectic Behavioural Therapy

Dialectic Behavioural Therapy (DBT) was developed by Marsha Linehan to treat patients with high suicidality who are not responding to standard cognitive-behavioural therapy. DBT incorporates components of dialectics and validation to improve the therapeutic efficacy [16,17].

DBT is based on a transactional model that explains that people with a high emotional sensitivity, when they are in invalidating environments, develop problems in terms of emotional regulation, and also cognitive, behavioural, and interpersonal difficulties [18]. This therapy is structured and manualized, and this facilitates its understanding and application by the therapists [4,5].

DBT deals with emotional dysregulation, which is considered the centre of several problems associated with BPD, as impulsivity, self-lesions, and problems in interpersonal relationships. Therapy includes learning emotional regulation skills, stress tolerance, and interpersonal effectiveness [19,20].

- √ **Learning skills include:** Helping to learn new psychological, emotional, and social skills.
- √ Generalizing these skills to real situations that have elicited less effective responses in the past (homework).
- √ Collaborating on treatment goals and improving motivation to replace dysfunctional behaviours with more skilful ones.
- √ Managing social and family relationships to achieve more support, understanding, and validation.

The general objective of DBT is to improve the wellness of the patients in their daily life, with specific objectives around the learning of the skills:

- Interpersonal chaos: interpersonal effectiveness skills.
- Affects, emotions, and labile moods: emotional regulation skills.
- Impulsivity: distress tolerance skills.
- Confusion about the self, cognitive dysregulation: basic awareness skills.

This therapy uses techniques as mindfulness, validation, and problem resolution to help patients leave away the dichotomic thought and to accept the complexity. DBT combines a realistic, irreverent, and paradoxical attitude towards dysfunctional behaviours, such as parasuicidal ones, with notable warmth, flexibility, close attention, and strategic self-disclosure by the therapist. The therapist maintains the balance between two seemingly opposing therapeutic styles.

In summary, DBT is a structured and based in validation that looks to improve emotional regulation and interpersonal efficacy in patients suffering from BPD, helping them to manage their high emotional sensitivity and to develop skills to face their problems more effectively. Usually, DBT needs weekly group and individual therapy.

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Mentalization-based Treatment

Mentalization-based Treatment (MBT) approaches the symptoms of BPD as a result of pre-mentalizing psychic functioning modes, which appear in response to hyperactivation of the attachment system that leads to suppression of the mentalizing function. This model is centred on repairing the mentalization capacity to improve the interpersonal relationships and the emotional regulation [21].

Mentalization is a mental process through which intentions are attributed to others and one's intentions are recognized; it is the way we can understand that others and ourselves are driven by underlying motivations, recognizing that these take the form of different thoughts, beliefs, desires, and emotions etc. One of the requirements for maintaining good interpersonal relationships is that we understand each other and ourselves reasonably accurately.

Mentalization dysfunctions often produce misinterpretations of mental states. The deterioration of emotional regulation means that one remains stuck in a painful, uncomfortable, and often confusing emotional state, possibly resorting to drastic means to try to escape it. Such emotional states can lead to highly self-destructive acts. Fonagy describes BPD as related to the instability of mentalization.

Following the MBT model, the symptoms surge when mentalization is suppressed partially in situations of high emotional activation, especially in intense attachment relations and early traumas, which allows the surge of pre-mentalizing modes as psychic equivalence and simulated modes [10,22].

The capacity for mentalizing is closely related to the attachment system; in BDP is common to have insecure attachment, particularly disorganized, affecting the self-representation and the perception of internal and external states. Epistemic trust allows the transmission of social norms and cultural knowledge, and it is necessary for the child to have trust in his caregivers as reliable learning sources [23,24]. Difficulties in regulating emotions provoke painful and confusing emotional states that can lead to auto-destructive behaviours [25,26].

In MBT, the therapist adopts a curiosity and "no knowing" posture, to help the patient to examine his/her thoughts and emotions, promoting alternative perspectives, less threatening, and stabilizing the mentalization in the context of attachment activation [21]. Dimensions in mentalization include automatic and controlled modes, emotions and thoughts, internal and external perspectives, and implicit and explicit processes, that must be equilibrated to reach an effective mentalization.

The therapeutic strategies include the promotion of mentalization through support, clarification, challenge, interpretation, and reflection over the therapeutic relationship, adapting the intervention to the mentalization capacity and the patient's emotional intensity [21,23].

MBT combines individual and group therapy in phases that include evaluation, mentalizing work, and preparation for the end of the treatment; it requires experienced and flexible therapists due to the emotional intensity of the patients with BPD [26].

Transference Focused Psychotherapy

Transference Focused Psychotherapy (TFP) is a psychodynamic approach designed to treat personality disorders, especially those with a borderline organization, working mainly through the transference relationship between patient and therapist to integrate fragmented object relations experiences [10].

The TFP is based on the theory of object relations, considering that the first internalized relational experiences affect the personality structure and dysfunctions in these relations can cause disorders as the borderline organization [27]. A healthy representation world is characterized by the ability to access internal images at any time, regardless of the situation and the presence of others.

If there is a structural disorder, only internalized partial object relationships can be accessed, which subsequently determine experiences; in particular, partial object relationships with another valence cannot be accessed. The organization that occurs in the case of structural disorders is called identity diffusion and is accompanied by so-called primitive defense mechanisms.

Kernberg describes three levels of personality organizations: neurotic, borderline, and psychotic structures, characterized by differences in identity integration, defense mechanisms, and reality testing [28].

The structural interview (STIPO) allows a detailed diagnosis of the personality structure in seven dimensions (Identity, Object relations, Primitive defenses, Rigidity, Aggression, Moral values, and Reality perception), facilitating an individual and categoric profile [12].

TFP is used to treat personality disorders with a borderline organization, except antisocial personality, due to their level of dishonesty that hinders psychotherapy. There is an adaptation for a narcissistic personality. Its focus is to analyse and modify dysfunctional relational patterns [29].

For the treatment, it is important to have the agreement of a contract between the therapist and the patient before the beginning of the therapy, as a way to assure the regularity and active participation, prioritizing the safety of both members of the dyad and removing therapy threats before working on the transference [27]. One of the main strategies of TFP is the analysis of the transference, mainly on the rupture of the framework and the contract.

The therapeutic techniques that are used in TFP are clarification, confrontation, interpretation, and working through the transference processes to integrate split self-parts and internal objects [27]. Strategic principles and tactics include naming the dominant object relations, observing the role reversal and internal conflicts, during different phases,

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and applying tactics to maintain the therapeutic framework and progress [30].

TFP is efficient in reducing suicidal behaviours and improving reflexive functions. TFP is focused on the character structure, more than on symptoms. It requires therapists with psychoanalytic formation and constant supervision (28). TFP is developed for two individual therapeutic sessions weekly. It is important that the patient has life and therapy objectives, and the compromise of having some activity in real life.

General Psychiatric Management (GPM)

General Psychiatric Management (GPM) is a therapeutic approach designed to treat BPD in community mental health services, aiming to be accessible to several mental health professionals, so the prognosis can be improved with less intensive but effective interventions [10]. This model emphasised the management of interpersonal hypersensitivity, psychoeducation, and support in real life, with a pragmatic approach, centred on the therapeutic relationship.

GPM was developed to surpass the difficulties and negative attitudes towards BDP treatment, providing a less specialized, but effective, method that reduces the withdrawal rate and improves the following [31].

GPM supposed that the core of BPD is interpersonal hypersensitivity, which implies that a perception of neglect or rejection generates intense emotional responses that affect the patient's behaviour. The therapy looks for helping to help understand and communicate these emotions [32].

Among the key components of the treatment, there are psychoeducation about the disorder, informed management of the psychopharmacology, emphasis on "work before love" and weekly individual sessions, with controlled access for the crisis [31,33,34]. The therapist must be active, validating the patient's experience and supporting them/her focusing on real-life situations. A component of this approach is the professional relationship, waiting for gradual progress, and improving the patient's autonomy.

GPM uses several specific interventions, as autobiography, behavioural chain analysis, secure plans for suicide management, and attention to factors that increase or decrease suicide risk [35]. To evaluate intensity and lethality of the suicide attempts, and the risk of suicide, it is important to develop and review from time to time a collaborative secure plan, applying clear principles for the crisis management and post-crisis follow-up [31].

GPM avoids direct interpretation of transference due to the understanding of emotional expressions as a demonstration of emotional deficits, not of conflicts. Supervision is necessary to manage negative countertransference.

With this approach, the therapist hopes that the patient shows an improvement in decreasing auto-destructive behaviour, introspection skills, social and interpersonal functioning, evaluating the therapeutic relationship, and the symptomatology. If the improvement is not shown in some time, the therapist must consider referral to a more specialized therapy if it is necessary [31].

Treatment options

There are multiple therapeutic options to treat Borderline Personality Disorder (BPD), each of with specific objectives and perspectives, that must be adapted to the clinical situation of the patient. Integration and combination of these approaches can optimize the results of the disorder [8,29,36].

Related to objectives and priorities, DBT, MBT, TFP, and GPM look for giving up on auto-destructive behaviour and stabilizing mental functions and interpersonal relationships. These therapies prioritize aspects as suicidality, life quality, and interpersonal relationships. Each one has a particular emphasis, as has been explained here, as the chain analysis on DBT or transference interpretation in TFP [37].

These different approaches differ also in their intensity and type of components, as case management, psychoeducation, group and individual therapy, and family therapy, with variations in frequency and emphasis depending on the method. DBT and MBT include essential group therapy, TFP usually has an individual framework, and GPM offers a more accessible and flexible approach (Table 1).

New alternatives in the treatment of BDP are directed to use the previous models depending on the patient's moment or their psychopathology, integrating the different psychotherapies. MBT and GPM are more compatible to be combined with other models, some DBT strategies can also be shared, and TFP is shared or integrated more easily than the others (8,29). This integration can be done in several ways:

- **Step-by-step progression:** using specific techniques for different symptoms or phases of treatment sequentially, initially DBT for auto-destructive behaviours, followed by TFP for a deep psychological work, or GPM in the beginning to allow organization and self-consciousness, followed by one of the more intensive therapies.

- **Technical eclecticism:** formulation of the patient's problems, paired with structured objectives, proposing which strategies and when they will be used, implies that the patient can benefit from the best strategies of each type of therapy, reducing the need to fit into a specific model. Clinical eclecticism allows for adaptation of strategies depending on the case formulation. It requires advanced knowledge and experience of the clinician team.

- **Synthesis:** the clinician considers the shared factors of the four strategies for their work, developing a stable and productive working alliance with patients with BPD. The four therapies for BPD share the therapist's attitude and focus. It requires a well-trained clinician.

The four therapies share an active, collaborative, and non-defensive attitude of the therapist, emphasizing validation and

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empathy. DBT and MBT prioritize warmth and validation before the change, TFP uses confrontation to integrate emotions, and GPM balances support and scepticism in dependence relationships. These attitudes look for integration and dialectic thought in the treatment (Table 2).

In general, early interventions should be prioritized with a proactive therapeutic position [38]. There are some adolescent-adapted psychotherapies, as DBT or MBT, but it is recommended to use different settings for sessions and different professionals, and also the association of somatic-based interventions, as relaxation.

The first-line treatment is a psychotherapy developed for BPD. DBT is the most widely used, but MBT, TFP, and SFT also produce changes in fronto-limbic circuitry, as well as reducing amygdala hyperactivation [39].

Schema-focused Therapy (SFT) for BDP

SFT is based on Young's model of Early Maladaptive Schema, developing the schema-focused therapy, integrating cognitive therapy with Gestalt and object relations techniques, for the treatment of people who have not responded to traditional cognitive treatment.

An Early Maladaptive Schema (EMS) is "an extremely stable and enduring pattern of thinking, feeling, and behaving that develops during childhood and is elaborated throughout an individual's life" [40]. The schemas are accepted completely as a central part of the identity, resulting in resistance to change.

The mean schemas are evidenced by the patient's statement about oneself. Usually, the schemas are related to one another, interplaying in a way that one maintains the other. Once EMSs are identified and, also, the relationship among them is understood, the therapist would help the patient to understand how they are activated and how they are related to the life problems [40]. The three major schema processes are maintenance, avoidance, and compensation.

In SFT, the emphasis on affective experience and therapeutic relationship is considered throughout the treatment. The stages of SFT are assessment (psychoeducation about the model and EMSs), conceptualization (origin of EMSs and present influence), intervention (test EMSs and find alternative explanations), and evaluation (consolidate new skills). The goal of the treatment is to identify, challenge, and modify EMSs, improving the patient's strengths and creating more adaptive schemas [40].

SFT can be used in individual and group settings, as well as a short-term group schema therapy for its use in primary care (Re-Focus), with 16 sessions [41].

Young proposed some EMSs as central in BDP, those related to abandonment, dependence, mistrust, abuse, subjugation,

Table 1: Comparison among the four Evidence Psychotherapies for BPD Characteristics of the four evidence-based therapies.

	DBT	MBT	TFP	GPM
Objetives	Abandoning the hell Effectiveness A life that is worth living	Stabilizing mentalization and the bond system	Integrating the splitting object relationships. Arrive at a depressive position (tolerate the loss of the ideal object)	Self-confidence First work, then love
Priorities	Suicidability Behaviors that interfere with the therapy and with the quality of life	Focus on interpersonal relationships	Transference Split object relations	Focus on interpersonal interactions
Management of suicidability	Chain analysis All day letters	Chain analysis	Interpretation of motivation and distortions	Risk valuation Chain análisis
Crisis plan	Independence skills, then coaching skills. Minimizing emergency use.	In working hours, call the mentalization team. Out of it: an emergence room.	Emergence room	Contact the algorithm or crisis plan.

Modified from Choi-Kan, et al. [8]

Table 2: Stages of BPD to implement the step-by-step strategy.

Clinical State	Severity	Definition	Potential Interventions
Preclinical	Subthreshold	High risk of BPD Mild or non-specific self-regulation problems	Psychoeducation (patient and family) Supportive counselling and problem-solving
Initial-Middle	First episode of BPD	+self-injury -suicidality	GPM Case management DBT skills group
Moderate	Evident symptoms	Lack of response to basic treatment +self-injury	GPM with medication management DBT skills training Single-model EBT (DBT, MBT, or TFP)
Severe	Remissions and relapses	+severe self-injury +potentially lethal suicide attempts	GPM-informed medical management Higher level of care (residential or intensive outpatient), Change single-model EBT or integrate EBTs
Chronic Persistent	No remissions	Lack of response to intervention Lack of response to previous stage interventions	GPM Supportive therapy

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emotional deprivation, and insufficient self-discipline, and the intensity of EMSs is also related to BDP severity [42].

EMDR and BDP

Borderline Personality Disorder (BPD) is marked by emotional instability, impulsivity, and interpersonal difficulties, with a high prevalence of early traumas that contribute to its development [43,44]. EMDR therapy, based on the Adaptive Information Processing (AIP) model, has demonstrated efficacy in the treatment of traumatic memories in BPD patients, improving symptoms of BPD and associated PTSD [45,46].

More than 75% of the BDP patients have antecedents of trauma, abandonment, or neglect during their infancy that facilitate dysfunctional traits and the characteristic symptoms of the disorder [47,48]. Between 30% and 70% of people with BDP have diagnostic criteria of PTSD, and this comorbidity impairs the quality of life and increases the symptomatology.

Psychological problems emerge due to non-processed traumatic experiences, and, in personality disorders, a deficit in adaptive information processing contributes to the presentation of pathology that requires treatment [49]. EMDR can be used in environments with high emotional dysregulation, as hospitalizations, with intensive and frequent sessions to reduce re-traumatization and improve stabilization [46,48,50].

EMDR can be a good complement to therapies as DBT, MBT, or GPM. In crisis trauma, focused, intensive treatments result in being effective. A major challenge in EMDR for BDP is that multiplicity and fragmentation of traumatic memories hinder the identification of objectives for the therapy, which requires clear criteria for its selection [45]. The processing of infant trauma with EMDR during the initial phases of the treatment improves the prognosis and reduces the therapy withdrawal.

De Jogh, et al. recommend a structured process to identify and treat traumatic memories, following their impact and age of onset, using the standard protocol for EMDR.

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