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PSYCHOTHERAPEUTIC AND PHARMACOLOGICAL INTERVENTIONS IN THE TREATMENT OF BORDERLINE PERSONALITY DISORDER

INTERVENÇÕES PSICOTERAPÊUTICAS E FARMACOLÓGICAS NO TRATAMENTO DO TRANSTORNO DE PERSONALIDADE BORDERLINE

INTERVENCIONES PSICOTERAPÉUTICAS Y FARMACOLÓGICAS EN EL TRATAMIENTO DEL TRASTORNO DE PERSONALIDAD BORDERLINE

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ABSTRACT

Borderline Personality Disorder (BPD) is a debilitating psychiatric condition characterized by a persistent pattern of instability in interpersonal relationships, self-image, and affects, as well as marked impulsivity, imposing a significant burden on healthcare systems due to high rates of self-harming behaviors and suicide attempts. The clinical management of BPD establishes psychotherapy as the gold standard of treatment, while pharmacological interventions remain strictly adjunctive tools, often used to manage the high rate of associated comorbidities. This study is a narrative literature review, developed through data collection from the PubMed and Cochrane Library databases, with the objective of compiling and analyzing current scientific evidence on therapeutic interventions for BPD. The findings indicate that structured psychotherapies, such as Dialectical Behavior Therapy (DBT) and Mentalization-Based Treatment (MBT), are established as first-line interventions, demonstrating robust results in reducing emotional dysregulation and impulsive behaviors. In contrast, the evidence for the efficacy of pharmacotherapy alone on the core symptoms of BPD is limited and of low certainty, with no medication specifically approved for the disorder. The use of medications, such as anticonvulsants and second-generation antipsychotics, is predominantly off-label, focused on mitigating specific target symptoms (such as anger and affective instability) or managing comorbidities. A favorable prognosis depends on the integration of evidence-based approaches, prioritizing functional recovery and overcoming institutional and social stigma.

Keywords: Borderline Personality Disorder (BPD). Psychotherapy. Pharmacotherapy. Dialectical Behavior Therapy. Comorbidities.

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RESUMO

O Transtorno de Personalidade Borderline (TPB) é uma condição psiquiátrica debilitante caracterizada por um padrão persistente de instabilidade nos relacionamentos interpessoais, na autoimagem e nos afetos, além de uma marcante impulsividade, impondo uma carga significativa aos sistemas de saúde devido às altas taxas de comportamentos autolesivos e tentativas de suicídio. O manejo clínico do TPB estabelece a psicoterapia como o padrão-ouro de tratamento, enquanto as intervenções farmacológicas permanecem como ferramentas estritamente adjuvantes, frequentemente utilizadas para manejar a alta taxa de comorbidades associadas. Este estudo configura-se como uma revisão bibliográfica narrativa, elaborada a partir da prospecção de dados nas bases PubMed e Cochrane Library, com o objetivo de compilar e analisar as evidências científicas atuais sobre as intervenções terapêuticas para o TPB. Os achados indicam que psicoterapias estruturadas, como a Terapia Dialética Comportamental (DBT) e o Tratamento Baseado na Mentalização (MBT), consolidam-se como intervenções de primeira escolha, demonstrando resultados robustos na redução da desregulação emocional e de comportamentos impulsivos. Em contrapartida, as evidências de eficácia da farmacoterapia isolada sobre os sintomas centrais do TPB são limitadas e de baixa certeza, com nenhuma medicação aprovada especificamente para o transtorno. O uso de fármacos, como anticonvulsivantes e antipsicóticos de segunda geração, é predominantemente off-label, focado em mitigar sintomas-alvo específicos (como raiva e instabilidade afetiva) ou no manejo de comorbidades. O prognóstico favorável depende da integração de abordagens baseadas em evidências, priorizando a recuperação funcional e a superação do estigma institucional e social.

Palavras-chave: Transtorno de Personalidade Borderline (TPB). Psicoterapia. Farmacoterapia. Terapia Dialética Comportamental. Comorbidades.

RESUMEN

El Trastorno de Personalidad Borderline (TPB) es una condición psiquiátrica debilitante caracterizada por un patrón persistente de inestabilidad en las relaciones interpersonales, la autoimagen y los afectos, además de una marcada impulsividad, lo que impone una carga significativa a los sistemas de salud debido a las altas tasas de conductas autolesivas e intentos de suicidio. El manejo clínico del TPB establece la psicoterapia como el estándar de oro del tratamiento, mientras que las intervenciones farmacológicas permanecen como herramientas estrictamente adyuvantes, frecuentemente utilizadas para manejar la alta tasa de comorbilidades asociadas. Este estudio se configura como una revisión bibliográfica narrativa, elaborada a partir de la recopilación de datos en las bases PubMed y Cochrane Library, con el objetivo de compilar y analizar la evidencia científica actual sobre las intervenciones terapéuticas para el TPB. Los hallazgos indican que las psicoterapias estructuradas, como la Terapia Dialéctica Conductual (DBT) y el Tratamiento Basado en la Mentalización (MBT), se consolidan como intervenciones de primera línea, demostrando resultados robustos en la reducción de la desregulación emocional y de los comportamientos impulsivos. En contraste, la evidencia de eficacia de la farmacoterapia aislada sobre los síntomas centrales del TPB es limitada y de baja certeza, sin existir medicación aprobada específicamente para el trastorno. El uso de fármacos, como anticonvulsivantes y antipsicóticos de segunda generación, es predominantemente off-label, enfocado en mitigar síntomas diana específicos (como la ira y la inestabilidad afectiva) o en el manejo de comorbilidades. Un pronóstico favorable depende de la integración de enfoques

basados en evidencia, priorizando la recuperación funcional y la superación del estigma institucional y social.

Palabras clave: Trastorno de Personalidad Borderline (TPB). Psicoterapia. Farmacoterapia. Terapia Dialéctica Conductual. Comorbilidades.

1 INTRODUCTION

Borderline Personality Disorder (BPD) is a debilitating psychiatric condition characterized by a persistent pattern of instability in interpersonal relationships, self-image, and affects, as well as marked impulsivity (Choi-Kain et al., 2022; Gartlehner et al., 2021). With an estimated prevalence of between 0.4% and 3.9% in the general Western population, the disorder imposes a significant burden on healthcare systems due to high rates of self-injurious behaviors and suicide attempts (Gartlehner et al., 2021). The neurobiological signature of BPD involves frontolimbic dysfunctions that manifest as emotional hypersensitivity, which serves as the basis for leading contemporary therapeutic approaches (Choi-Kain et al., 2022; Ford and Courtois, 2021).

The clinical management of BPD has evolved considerably, establishing psychotherapy as the gold standard of treatment, while pharmacological interventions remain as adjunctive tools (Choi-Kain et al., 2022; Stoffers-Winterling et al., 2022). However, a persistent challenge lies in the high rate of comorbidities—such as depression, anxiety, and substance use disorders—which often leads to polypharmacy and complicates prognosis (Pascual et al., 2023; Szabó and Miklósi, 2024). In addition, the diagnostic distinction between BPD and Complex Post-Traumatic Stress Disorder (PTSD-C) is critical for the selection of the most appropriate therapeutic strategy (Ford and Courtois, 2021). Given the complexity of this pathology, the integration of evidence-based protocols is essential for clinical stabilization and functional recovery of the patient (Choi-Kain et al., 2022; Pascual et al., 2023).

Longitudinal studies have clarified the clinical course of the disorder. Although symptomatic remission is relatively frequent (about 85% in ten years), complete functional recovery remains rarer and more unstable. Many patients continue to have significant occupational, social, and interpersonal impairments, in addition to greater use of health services, revealing a clear dissociation between symptom control and global improvement in functioning (Choi-Kain et al., 2022). This reality reinforces the need for treatments that go beyond symptomatic reduction and prioritize functional outcomes. In addition, the morbidity and mortality associated with BPD is high: the disorder is linked to frequent self-injurious behaviors, multiple suicide attempts throughout life, and suicide mortality that can reach 10%, configuring a relevant public health problem (Choi-Kain et al., 2022).

From an etiological point of view, the stress-diathesis model remains the most consistent. The interaction between genetic vulnerability and early traumatic experiences, especially emotional abuse, neglect, and childhood sexual abuse, increases the risk of BPD by up to 30 times when compared to individuals without psychopathology (Ford & Courtois, 2021; Gartlehner et al., 2021).

Despite advances, the diagnosis of BPD continues to generate debate. Roger Mulder, chair of the World Psychiatric Association's Personality Disorders Working Group, argues that the current concept does not meet modern scientific standards. The criteria are vague and overly broad, comorbidity reaches 90%, factor analyses do not identify a specific "borderline" factor (symptoms merge into a general personality psychopathology factor, the "g-factor"), there are no specific treatments proven to be effective, and the stigma attached to the diagnosis undermines the recognition and proper management of other conditions (Mulder & Tyrer, 2023; Szabó & Miklósi, 2024).

In this scenario, the dimensional models proposed by the ICD-11 gain relevance. They prioritize the assessment of the severity of personality dysfunction and dominant traits, including the borderline pattern, which allows for a more individualized and clinically useful description, overcoming limitations of traditional categorical systems, such as heterogeneity and stigmatization (Szabó & Miklósi, 2024).

Regarding pharmacological treatment, recent systematic reviews show that, despite the widespread prescription of psychotropic drugs (often in polypharmacy), evidence of efficacy on the core symptoms of BPD remains limited. Antipsychotics, antidepressants, and mood stabilizers offer, at best, modest and inconsistent effects, with low impact on core outcomes such as disorder severity, suicidal behavior, and psychosocial functioning (Stoffers-Winterling et al., 2022; Gartlehner et al., 2021).

Psychotherapy, in turn, continues to be the first-line treatment, with increasing emphasis on brief, generalist, and early formats, such as adaptations of Dialectical Behavior Therapy and Mentalization-Based Therapy, aimed at functional improvement and reduction of disabilities (Choi-Kain et al., 2022).

Finally, the interface between BPD and Complex Post-Traumatic Stress Disorder (PTSD-C) has received special attention. Although both are often comorbid and share emotional dysregulation and a history of early interpersonal trauma, they are distinct entities. PTSD-C is marked by disturbances in self-organization (chronic emotional numbing, stable negative self-perception, and relational avoidance), while BPD is

characterized by extreme emotional lability, terror of abandonment, and hostile impulsivity in relationships. This differentiation is key to guiding specific interventions (Ford & Courtois, 2021).

Given this body of epidemiological, neurobiological, phenomenological, and therapeutic evidence, the integration of evidence-based approaches emerges as a clinical and scientific imperative. A more refined view of the overlaps and differences between BPD, C-PTSD, and general personality dysfunction, combined with the recognition of the limitations of pharmacotherapy and the weight of stigma, paves the way for more personalized, early, and functioning-centered interventions. The present article seeks to contribute to this advance through a critical and updated review of the literature, pointing out directions for future research and for excellent clinical practice.

2 METHODOLOGY

This study is a narrative literature review, developed with the objective of compiling and analyzing current scientific evidence on psychotherapeutic and pharmacological interventions in Borderline Personality Disorder. Data were prospected in the PubMed database and in the Cochrane Library, using the descriptors "Borderline Personality Disorder" and "Therapeutics", articulated through the Boolean operator AND, according to the terminology MeSH (Medical Subject Headings). Articles published in the last five years, with full text available and written in Portuguese or English, that directly addressed the topic, were selected for analysis. Productions with low methodological rigor, duplicates, and studies without focus on treatment modalities were excluded. The selection process took place in two stages: initial screening of titles and abstracts, followed by the full analytical reading of the selected texts to confirm relevance. The information extracted was organized in a descriptive and critical manner.

3 RESULTS

The scientific literature points out that psychotherapy is the primary and most effective intervention for BPD. Modalities such as Dialectical Behavioral Therapy (DBT) and Mentalization-Based Treatment (MBT) demonstrate robust results in reducing emotional dysregulation and impulsive behaviors (Choi-Kain et al., 2022). Recently, there has been a trend towards the use of less intensive and generalist management formats,

such as *Good Psychiatric Management* (GPM), which has proven to be as effective as specialized therapies for many patients (Choi-Kain et al., 2022).

From a neurobiological point of view, neuroimaging studies show an anomalous activation in certain brain areas. The hyperfunction of the Default Mode Network (DMN), which activates in moments of introspection and rumination, may be the neurophysiological basis of certain behaviors and profound mood swings. In contexts of social exclusion and rejection, these networks are overstimulated, culminating in episodes of sadness or reactional aggressiveness. These results reinforce the importance of therapeutic approaches to improve self-control and define strategies for a better quality of life (CHOI-KAIN et al., 2022).

In view of these findings, dynamic deconstructive psychotherapy has also shown favorable results in reducing extremist thoughts, improving emotional processing, and managing comorbidities such as PTSD and substance abuse. The most current guidelines emphasize the importance of other approaches such as psychoeducation of family members and cohabitants to expand knowledge about BPD and understand the patient's condition. This approach increases the effectiveness of treatment and improves family quality of life (CHOI-KAIN et al., 2022).

In the field of pharmacology, the evidence is more limited. To date, no medication has been approved by regulatory agencies specifically for the treatment of BPD (Gartlehner et al., 2021). The Cochrane systematic review indicates that the certainty of the evidence for the use of mood stabilizers and antipsychotics is low; no single drug has demonstrated a clear benefit on the overall severity of the disorder (Stoffers-Winterling et al., 2022). However, in clinical practice, anticonvulsants (such as topiramate and lamotrigine) and second-generation antipsychotics (such as aripiprazole and quetiapine) are often prescribed off-label to mitigate specific symptoms of anger, affective instability, and transient psychotic symptoms (Gartlehner et al., 2021; Pascual et al., 2023). The management of comorbidities requires caution, prioritizing the treatment of the primary condition without neglecting the underlying personality dynamics (Pascual et al., 2023).

Thus, the association of BPD with other psychiatric disorders is frequent. Although there are no pharmacological therapies specifically approved for BPD, it is common to prescribe different classes of drugs outside the formal indications, such as antidepressants, especially selective serotonin reuptake inhibitors (SSRIs), mood stabilizers, second-generation antipsychotics, and benzodiazepines. However,

guidelines on this off-label use are heterogeneous, showing a lack of consensus among clinical guidelines (Pascual et al., 2023).

The presence of psychiatric comorbidities is the main factor related to the indication of pharmacological treatment and the use of polypharmacy, especially in cases of affective, anxiety, and eating disorders. Even so, there is widespread use of medications in individuals with borderline personality disorder (BPD), even in the absence of other associated conditions. In a study with 457 patients with BPD, approximately 80% of those without comorbidities used some medication: 62.9% used antidepressants, 59.7% benzodiazepines, 22.6% mood stabilizers, and 27.4% antipsychotics. In addition, about 42% of these patients were on polypharmacy (Martín-Branco et al., 2017).

Antidepressants, especially selective serotonin reuptake inhibitors (SSRIs), such as citalopram and fluoxetine, are among the most frequently prescribed classes for BPD, although there is little consistent evidence to support this practice. The use of mood stabilizers, such as topiramate and valproate, in individuals with BPD is often related to the presence of anxiety symptoms and eating disorders. In contrast, the prescription of antipsychotics, especially second-generation antipsychotics, such as quetiapine and olanzapine, do not demonstrate a consistent association with specific comorbidities (Pascual et al., 2021).

However, lamotrigine has also been associated with benefits in cases of treatment-resistant major depression. Small preliminary studies have indicated a possible effect of this drug in reducing impulsivity, anger, and behavioral dysregulation in individuals with BPD (Sotofferes et al., 2022). However, a larger-scale randomized clinical trial (n = 276) did not demonstrate efficacy of lamotrigine (400 mg/day) in managing BPD symptoms (Crawford et al., 2018).

As for benzodiazepines, their prescription should be made with great caution in the management of comorbidities such as generalized anxiety disorder (GAD) and agoraphobia, due to their potential adverse effects. Although they offer quick relief for exacerbations, possible deleterious effects such as behavioral disinhibition, increased suicidal tendencies, and the high capacity to cause dependence on this pharmacological class stand out. Therefore, it is up to the health professional to prioritize safer pharmacological options, taking into account the patient's profile, individualizing the approach (PASCUAL et al., 2023).

4 DISCUSSION

Scholarly discussion about the treatment of BPD reveals a paradox: although medication is widely used (up to 96% of patients receive at least one psychotropic drug), its role should be strictly secondary (Gartlehner et al., 2021; Stoffers-Winterling et al., 2022). Drug overuse can in some cases obscure symptoms and delay engagement in psychotherapy, which is where structural modification of emotion regulation occurs (Choi-Kain et al., 2022; Szabó and Miklósi, 2024). Critics such as Roger Mulder argue that the diagnostic criteria for BPD are vague and that the stigma associated with the label often impairs the recognition of the patient's other somatic or psychiatric difficulties (Szabó and Miklósi, 2024).

The scientific literature also warns of the frequent polypharmacy among these patients. Although health guidelines prioritize psychotherapy, clinical practice reveals a scenario where the first therapeutic option for comorbidities such as major depressive disorder (MDD) and substance abuse is still pharmacotherapy. The difficulty in implementing these recommendations often occurs due to the unavailability of specialized cognitive behavioral therapy, patient preference to be medicated, and communicative barriers in the doctor-patient relationship. In this sense, pharmacological therapy should be offered in order to complement psychotherapy and avoid possible iatrogenic events (PASCUAL et al., 2023).

Another central point of debate is the relationship to trauma. Although BPD and Complex PTSD share a history of trauma and self-regulation difficulties, BPD is distinguished by a chronic instability in self-identity and perceived abandonment (Ford and Courtois, 2021). The prognosis for BPD is generally favorable in the long term with early intervention, but the persistence of residual symptoms requires ongoing support networks (Choi-Kain et al., 2022). Advances in digital interventions, such as symptom monitoring apps, and neuromodulation-based therapies show promise, although they still require further clinical validation (Choi-Kain et al., 2022). In sum, effective treatment of BPD requires a psychotherapy-centered approach, with judicious and symptom-specific use of medication, integrating the management of comorbidities and the reduction of institutional stigma (Pascual et al., 2023; Szabó and Miklósi, 2024).

5 CONCLUSION

The clinical management of Borderline Personality Disorder (BPD) is guided by the understanding of its diagnostic and etiological complexity. The definition of BPD moves towards the adoption of dimensional and hybrid models, as proposed by the ICD-11, in contrast to the discussion about the existence of a general factor of personality pathology. Neurobiological findings confirm BPD through frontolimbic dysfunction and interpersonal and emotional hypersensitivity. It is essential to distinguish between BPD and Complex Posttraumatic Stress Disorder (PTSD-C), conditions that, although they can be comorbid, are phenomenologically separable based on distinct self-organization and reactivity mechanisms.

As for treatment strategies, structured psychotherapies, such as Dialectical Behavioral Therapy (DBT) and Mentalization-Based Treatment (MBT), are consolidated as the interventions of choice, demonstrating satisfactory results in reducing the cardinal symptoms of the condition, such as emotional dysregulation, anger, and impulsivity. On the other hand, systematic reviews indicate that pharmacotherapy alone has reduced and often comparable effects to placebo in the control of core BPD symptoms.

Thus, the prescription of medications should be strictly adjunct, focused on the management of specific comorbidities (such as depression and substance abuse) and in crisis situations. In the absence of access to psychotherapy, in the face of an unsatisfactory response or due to patient preference, pharmacotherapy can be considered as an alternative management, but the decision should be shared and the patient should be duly informed about the potential benefits, limitations and risks.

The effectiveness of clinical follow-up depends on the implementation of early interventions and the transition from a model focused only on symptom remission to long-term psychosocial rehabilitation and the individual's social functioning, encompassing job stability and affective bonds. However, overcoming institutional and social stigma remains a critical challenge, as diagnostic labeling still hinders access to and quality of medical care.

In short, BPD is a complex and multifactorial entity that has serious consequences for mental health and social dysfunctions. It is essential that the healthcare professional adopts a holistic and individualized approach in order to avoid polypharmacy and its potential adverse effects. In this context, advancement in scientific productions and

clinical trials is imperative to reduce the therapeutic gap and lack of consensus in clinical practice.

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