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THE EFFICACY OF PSYCHOTHERAPY FOR BORDERLINE PERSONALITY DISORDER: A REVIEW

Ferran Burgal Juanmartí and Nathalie Pérez Lizeretti
Universitat Ramón Llull. CIDIE

El objetivo principal de este estudio fue comparar la eficacia de diferentes psicoterapias utilizadas para el tratamiento del Trastorno Límite de Personalidad (TLP) con el fin de analizar y comprender qué terapias obtienen mejores resultados y por qué. Para ello se llevó a cabo una revisión sistemática de las publicaciones realizadas desde 1990 en las principales bases de datos (PsyInfo, Medline, Psicodoc y Google Scholar). Los resultados mostraron por una parte, que las principales psicoterapias para el TLP eran la Terapia Dialéctica Conductual, la Terapia Basada en la Mentalización y la Terapia Basada en Esquemas entre otras y, por otra, que todas ellas eran eficaces. Hay que remarcar que cada una de dichas terapias, tal y como indican los resultados, era significativamente eficaz sobre diferentes problemáticas como el control de conductas autolíticas y autolesivas, no obstante, algunos aspectos como la regulación emocional seguían resistiéndose en muchos casos.
Palabras clave: *Trastorno límite de la personalidad, Revisión sistemática, Psicoterapia.*

The main objective of this investigation is the efficacy comparison of the different psychotherapies for Borderline Personality Disorder (BPD), with the aim of analyzing and understanding which therapies obtain better results and why. To this end, a systematic review was carried out on the current psychotherapies for BPD. First of all, the results showed that the psychotherapies most used for BPD were Dialectical Behavior Therapy (DBT), Mentalization-Based Treatment (MBT) and Schema-Based Therapy (SBT), among others, and all of them were efficacious. It should be noted that each of these therapies, as shown in the results, was efficacious in treating various symptoms, such as parasuicidal behavior control, however, some aspects such as emotional regulation were still resistant to treatment in many cases. Therefore, further investigations should be carried out to include elements of emotional regulation and measuring their efficacy.
Key words: *Borderline personality disorder, Systematic review, Psychotherapy.*

Borderline Personality Disorder (BPD) involves considerable suffering both for the individuals who suffer from the disorder and the people around them, as well as a high consumption of healthcare resources (Bender et al., 2001; Zanarini, Frankenburg, Hennen, & Silk 2004), not only due to its prevalence of 1-2% in the general population (APA, 2000, Lieb, Zanarini, Schmahl, Linehan, & Bohus, 2004) and 10-20% in psychiatric patients (Torgersen, Kringlen, Cramer, 2001), but also due to its nature (Linehan, Heidi, Heard, Hubert, & Armstrong, 1993). The characteristics of borderline behavior and resistance to pharmacological treatments make psychotherapy the key element for the improvement of these patients.

Currently there are multiple psychotherapies for the treatment of BPD with studies that support their effectiveness on the different conditions that make up the disorder. From here, one possible question to ask is what psychotherapy is most effective and why. The most studied and most empirically supported are: Dialectical Behavioral Therapy (DBT) (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991), Mentalization-Based Therapy (MBT) (Bateman & Fonagy, 2004), Transference-Focused Therapy (TFT) (Clarkin, Kernberg, & Yeomans, 1999), Schema-Based Therapy (SBT) (Ball & Young, 1999), Cognitive Analytic Therapy (CAT) (Ryle, 1991), Hobson's Conversational Therapy (HCT) (Hobson, 1985) and Cognitive-Behavioral Therapy (CBT).

DBT is a manualized psychotherapy, combining behavioral, cognitive and supportive strategies based on the duality of accepting the other in their present condition while promoting change (Heard & Linehan, 1994). On the contrary, MBT and TFT are psychoanalytic psychotherapies that focus on affect, comprehension, and interpretation, although there are also important differences between the two therapies. TFT pays special attention to transference and focuses its therapeutic action

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Correspondence: Ferran Burgal Juanmartí. *Blanquerna, Universitat Ramón Llull. Centro de Investigación y Desarrollo de la Inteligencia Emocional, Fundación Ramón Rosal Paseo de Rubí 56. 08197 Valldoreix. España. E-mail: ferranBJ1@blanquerna.url.edu*

on the externalizations of the patient in therapy. However, MBT first seeks emotional stabilization in order to, secondarily, work on mentalization and self-understanding (Bateman & Fonagy, 2004). As for SBT, it is based on cognitive-behavioral, psychodynamic, and emotion-centered theories, and it seeks to identify and modify the individual's internal structure (Kellogg & Young, 2006). CAT (Ryle, 1991) consists of a brief (16-session) focal and integrative therapy that includes psychodynamic and cognitive aspects. Finally Hobson's Conversational Therapy (Hobson, 1985) focuses on the emotions of the person and their interpersonal problems.

Numerous studies suggest that serious difficulties in emotional management are a central aspect in BPD (Harned, Banawan, & Lynch, 2006; Clarkin, Levy, Lenzenweger, & Kernberg 2007; Gardner & Qualter, 2009; Gardner, Qualter, & Tremblay, 2010; Peter et al., 2013). Some research studies have shown that low emotional intelligence (EI) occurs in BPD, which implies a poor understanding of one's own and others' emotions and mismanagement of these (Gardner et al., 2010; Lizeretti, Extremera, & Rodríguez, 2012; Peter et al., 2013). The results of these research studies show that people with BPD pay too much attention to their emotions but have difficulty in clearly identifying different emotional states and consequently managing them correctly. Therefore, understanding and managing emotions are key issues to be addressed in people with BPD.

The first objective of this study is to evaluate the efficacy results obtained by the different psychotherapies in the improvement of the disorder. Although there are some review studies on the efficacy of psychotherapy on BPD (e.g., Díaz, 2001; Lana & Fernández, 2013), there are few that analyze in detail the effectiveness of each of them at the symptomatic level. Our second objective is, therefore, to go beyond looking at which therapy is most effective and to find out which problems are susceptible to improvement and which ones are not in relation to each psychotherapy.

METHOD

Search strategy

A review of the literature was carried out in the PsyInfo, Medline, Psicodoc and Google Scholar databases between 1990 and 2015, taking into account that CBT, MBT and TFT first appeared in the 1990s. We used different combinations of the following search descriptors for the identification and inclusion of articles: ([borderline personality disorder] AND [psychotherapy treatment OR dialectical behavior therapy OR mentalization based therapy OR transference focused therapy OR schema based therapy OR cognitive behavior therapy]).

Selection criteria

We included studies that assessed the efficacy of psychotherapy in people with BPD, studies that compared the efficacy of two or more psychotherapies, and systematic review studies. We excluded studies whose main object of study was not the application of a psychotherapy. Finally, the sample of our study comprised a total of 30 articles, which analyzed the efficacy of a psychotherapy in people that have been diagnosed with BPD or borderline symptomatology.

RESULTS

The studies are distributed in three tables according to the psychotherapy studied. Each table includes the type of study, the sample, the therapeutic modality (individual, group or a combination) and the main results obtained.

Table 1 includes the efficacy studies of CBT, Table 2 lists those of the psychoanalytic-oriented psychotherapies, and Table 3 shows the other psychotherapies and includes clinical trials on the effectiveness of SBT, CBT, and CAT. The study by Leppänen, Hakko, Síntonen, & Lindeman (2016) is also included in this table because it presents a combination of DBT and SBT.

As shown in Table 1, the studies performed on DBT in BPD show a clear efficacy in multiple variables. The most relevant changes occur in autolytic and self-injurious behaviors, leading to a decrease both in hospital admissions and in the use of emergency services (Linehan et al., 1991; Linehan, Heard, & Armstrong 1993; Turner, 2000; Verheul et al., 2003; Bohus et al., 2004; Linehan et al., 2006; McMain, et al., 2009; Bedics, Atkins, Comtois, & Linehan 2012; Linehan et al., 2015; Stigmayr et al., 2014; Harned, Korsnlund, & Linehan, 2014). Significant changes were also observed in general psychopathology (Bohus et al., 2004, McMain et al., 2009, Stigmayr et al., 2014), borderline symptomatology (McMain et al., 2009; Stigmayr et al., 2014), general functioning (Linehan, Heard, & Armstrong, 1993; Linehan et al., 1999; Bohus et al., 2004; McMain et al., 2009), dissociations (Koons et al., 2001; Bohus et al., 2004; Harned et al., 2014; Stigmayr et al., 2014), and

TABLE 1
EFFECTIVENESS STUDIES OF DIALECTICAL BEHAVIOR THERAPY

Reference	N	Study characteristics	Therapeutic Mode	Measuring instruments	Effectiveness results
Linehan et al., (1991)	44 F	RCT.CG (TAU).DBT	G+I	Parasuicide History Interview (PHI), Depression Inventory (BDI), Scale for Suicide Ideators (SSI), Treatment History Interview (THI), Beck Hopeless Scale (BHS), Reasons for Living Scale (RLS), Survival and Coping Scale (SCS).	Significant reduction of self-injuries and hospitalizations.There were no significant improvements in depression, feelings of despair, suicidal ideation, or reasons for living.
Linehan, Heard & Armstrong (1993)	39 F	RCTCG (TAU).DBT	G+I	PHI, THI, Sate Trait Anger Scale (STAS), Global Assessment Scale (GAS), Social Adjustment Scale-Interview and Social Adjustment Scale-Self-Report (SAS-SR).	DBT was significantly more effective in feelings of anger, global functioning, parasuicidal behaviors and social adjustment.It was not in ruminative anxiety and work efficiency
Linehan et al., (1999).	28 F	RCT.CG (TAU).DBT	G+I	PHI, GAS, Global Social Adjustment (GSA), Social History Interview (SHI), State-Trait-Anger Inventory (STAXI).	DBT showed significant differences in substance abuse, adherence to therapy, and social and overall adjustment.There were no differences between groups in feelings of anger or parasuicidal behaviors.
Turner (2000)	19 F 5 M	RCT.CG (Patient Centered Therapy).DBT	G+I	Diagnostic Interview for Borderlines (DIB), Structured Clinical Interview for DSM-III Disorders (SCID-I)	DBT involved a significant reduction in the number of hospitalizations and parasuicidal behaviors.
Koons et al., (2001)	20 F	RCT.CG (TAU).DBT	G+I	PHI, THI, BDI, BHS, STAXI, Beck Scale for Suicide Ideation (BSSI), Hamilton Depression Scale (Ham-D), Hamilton Anxiety Rating Scale (HAM-A), Dissociative Experiences Scale (DES).	DBT showed significant improvements in depression, suicide, dissociation, and anger.There was no significant improvement in anxiety.
Verheul et al., (2003)	58 F	RCT.CG (TAU).DBT	G+I	Lifetime Parasuicide Count (LPC), Borderline Personality Disorder Severity Index (BPDSI-IV).	Increased adherence and improvement in self-injurious and autolytic behaviors with DBT.
Bohus et al., (2004)	50 F	NRCT.CG (TAU).DBT	G+I	LPC, HAM-A, BDI, Ham-D, STAXI, GAFSymptom-Checklist (SCL-90-R), State-Trait-Anxiety Inventory (STAI), Dissociations Experiences Scale (DES), Inventory of Interpersonal Problems (IIP).	Improvement in general psychopathology, self-injurious behavior, dissociation, depression, anxiety, interpersonal functioning and social adjustment.There was no significant improvement in feelings of anger.
Linehan et al., (2006)	101 F	RCT.CG (CTE).DBT	G+I	Ham-D, Suicide Attempt Self-Injury Interview (SASII), Suicidal Behaviors Questionnaire (SBQ), Reasons for Living Inventory (RLI) Treatment History Interview.	The DBT group showed fewer hospitalizations due to suicidal ideation and greater adherence to treatment.
McMain et al., (2009)	165 F 15 M	RCT.CG (general psychiatric care). DBT	G+I	SASII, SCL-90-R, STAXI, BDI, IIP, EQ-5D, THI.Zanarini Rating Scale for Borderline Personality Disorder (ZAN-BPD), Reasons for Early Termination From Treatment Questionnaire,	There were no significant differences between the groups in any of the variables analyzed.Significant improvements in DBT and CG: parasuicidal behaviors, borderline symptoms, general symptomatology, depression, anger, utilization of health services, and interpersonal functioning.
Axelrod, Perepletchikova, Hotlzman & Sinha (2011).	27 F	NRCT.No CG.DBT	G+I	BDI, Difficulties in Emotion Regulation Scale (DERS).	Significant improvement in emotional regulation, substance abuse, and depression.
Bedics, Atkins, Comtois &Linehan (2012)	101 F	RCT.CG (CTE).DBT	G+I	Benjamin's Structural Analysis of Social Behavior (SASB).	Individuals in the DBT group increased self-assertion, self-esteem and self-protection, and self-injurious behaviors decreased. Participants who perceived their therapist as protective and reaffirming had less self-injurious behaviors.
Linehan, et al., (2015)	99 F	RCT.DBT, DBT (Skills training), individual DBT.	G+I	SASII, Ham-D, HAMA, THI, Suicidal Behaviors Questionnaire, Reasons for Living Inventory (RLI).	The three modalities significantly reduce suicidal ideation, depression, severity of self-harm and the use of medical services due to autolytic attempts.At the general level, standard DBT performs better than the other two modalities.
Neacsiu et al., (2014)	101 F	RCT.CG (CTE).DBT	G+I	STAXI, Acceptance and action questionnaire (AAQ), Personal feelings questionnaire 2 (PFQ2), Taylor Manifest Anxiety Scale (TMAS).	DBT shows an improvement in the experience, expression and acceptance of negative emotions.No significant differences in reducing the intensity of negative emotional experiences like anger, anxiety, guilt and shame.
Harned, Korsnlund & Linehan (2014)	26 F	RCT.DBT,DBT+ PE (Prolonged Exposure protocol)	G+I	SCID-I, PTSD Symptom Scale-Interview (PSS-I), International Personality Disorder Examination (IPDE), Traumatic Life Events Questionnaire (TLEQ), 3-item Childhood ExperiencesQuestionnaire, Reasons for Termination-Client Scale, 8-item Client Satisfaction Questionnaire (CSQ), SASII, GSI, BSI, Ham-D, HAM-A, Dissociative Experiences Scale - Taxon (DES-T), Trauma-Related Guilt Inventory (TRGI), Experience of Shame Scale (ESS),	Both modalities were associated to improvements in the severity of Post-Traumatic Stress Syndrome, in dissociations, feelings of guilt, Anxiety, depression and overall functioning.DBT + PE significantly more effective in autolytic and self-injurious behaviors.
Stigmayr et al., (2014)	66 F 12 M	LS (4 years)No CG	G+I	BDI, Ham-D, Borderline Symptom List (BSL), Questionnaire of thoughts and feelings borderline-specific cognitions (QTF), Brief Symptom Inventory-Global Severity Index (BSI-GSI), Dissociation-Tension-Scale (DSS).	Decrease in self-harm and number of hospital admissions.Improvement in the severity of borderline personality symptoms, general psychopathology, depression, and dissociations.At the end of one year of treatment, 77% of patients no longer fulfilled the diagnostic criteria for BPD.

Notes: N (F=Female; M=Male), Type of Study (RCT= Randomized Clinical Trial; NRCT=Non-Randomized Clinical Trial; LS= Longitudinal Study), CG (TAU=Treatment as usual; CTE=Community Treatment from Experts); Therapeutic Mode (G=Group; I=Individual; G+I=Group and Individual)

depression (Koons et al., 2001; Bohus et al., 2004; McMain et al., 2009; Axelrod, Perepletchikova, Hotlzman, & Sinha, 2011; Linehan et al., 2015; Harned, Korsnlund, & Linehan, 2014; Stigmayr et al., 2014). However, in the study by Linehan et al. (1991) no improvement was observed in depression in the variables feelings of despair, suicidal ideation, or reasons for living.

It should be noted that DBT is less effective than expected in regulating the intensity of negative emotional experiences such as anger, guilt, anxiety, or shame (Linehan, Heard, & Armstrong 1993; Linehan et al., 1999; Koons et al., 2001; Bohus et al., 2004; Neacsiu et al., 2014). Although in two studies there was significant improvement in expressed and unexpressed anger (Koons et al., 2001; McMain et al., 2009) in the trial by McMain et al. (2009) the improvement was not superior to that of the control group. In two other studies, the variable anxiety gained significant improvements (Bohus et al., 2004; Harned, Korsnlund, & Linehan, 2014) and in one study there was an improvement in the experience, expression and acceptance of negative emotions but the capacity to regulate them did not improve (Neacsiu et al., 2014). Only in one of the trials performed based on DBT did the patients obtain a significant improvement in emotional regulation at the end of treatment (Axelrod, Perepletchikova, Hotlzman, & Sinha 2011).

In Table 2 we can see that the psychoanalytic psychotherapies used with BPD are TFT, MBT and Hobson's Conversational Therapy. TFT (Clarkin, Levy, Lenzenwerger, & Kernberg, 2007; López et al., 2004) showed a clinically significant improvement in anxiety, depression, overall functioning, suicidal behavior, social adjustment, irritability, and aggressiveness. MBT (Bateman & Fonagy, 1999; Bateman & Fonagy, 2001; Bateman & Fonagy, 2008; Bateman & Fonagy, 2009) in anxiety, depression, general psychopathology, borderline symptoms, and overall and interpersonal functioning, as well as a decrease in autolytic and self-injurious behaviors. Finally, Hobson's Conversational Therapy (HCT) resulted in a significant improvement in BPD symptomatology and overall functioning.

TABLE 2
EFFECTIVENESS STUDIES OF PSYCHOANALYTIC-ORIENTED THERAPIES

Reference	N	Study characteristics	Therapeutic Mode	Measuring instruments	Effectiveness results
Bateman & Fonagy (1999)	22 F 16 M	RCT.CG (TAU).MBT	G+I	STAI, BDI, SCL-90, Social Adjustment Scale (SAS), IIP.	Improvement in self-harming and autolytic behaviors, depression, anxiety, general psychopathology, social adjustment, and interpersonal relationships.
Meares, Stevenson & Comerford (1999)	60	NRCT.CG (wait list)HCT.	I	DSM-III.	HCT showed a significant decrease in the diagnostic criteria with respect to the CG.
Bateman & Fonagy (2001)	44	LS (18 months).MBT	G+I	SCL-90-R, GSI, BDI, SAS, IIP.	The MBT group maintained the improvements at a symptomatic, social and hospital use level.
López et al., (2004)	10 F	NRCT.No CG.TFT	I	SCID I, SCID II, SCL-90, DSM-IV.	Improvement in symptomatic severity and overall activity.
Korner, Gerull, Meares & Stevenson (2006)	33 F 27 M	NRCT.CG (TAU).HCT.	I	Westmead Severity Scale, GAS, DSM-III-R.	Significant improvement with respect to CG in terms of reducing the severity of borderline symptoms and improving overall functioning.
Clarkin, Levy, Lenzenwerger & Kernberg (2007)	83 F 7 M	RCT.DBT, TFT and Support Therapy.	G+I (DBT)I (TFT)I (Support Therapy)	BDI, BSI, Global Assessment of Functioning Scale (GAF), Overt Aggression Scale-Modified, Social Adjustment Scale (SAS), Barratt Impulsiveness Scale-II, Anger Irritability and Assault Questionnaire.	DBT involved an improvement in 5 of the 12 variables analyzed (depression, anxiety, overall functioning, suicidal behaviors, social adjustment), TFT in 10 (the same ones as DBT + anger, Barratt Factor 2, irritability and verbal and direct aggression), and Support Therapy in 6 (depression, anxiety, global functioning, social adjustment, Barratt Factor 3 and anger).
Bateman & Fonagy (2008)	41	LS (5 years).CG (TAU).MBT	G+I	ZAN-BPD, GAF.	Significant clinical improvement with regard to CG in suicide, diagnostic criteria, utilization of mental health services, medication, global functioning and vocational status.
Bateman & Fonagy (2009)	107 F 27 M	RCT.CG (TAU).MBT	G+I	GAF, BDI, SCL-90-R, GSI, BDI, SAS, IIP.	Decrease in suicide attempts, self-harm, and hospital admissions.Improvement in general psychopathology, social adjustment, and interpersonal functioning.

Notes: N (F=Female; M=Male), Type of Study (RCT= Randomized Clinical Trial; NRCT=Non-Randomized Clinical Trial; LS= Longitudinal Study), CG (TAU=Treatment as usual; Therapeutic Mode (G=Group; I=Individual; G+I=Group and Individual)

Table 3 includes investigations of therapies that are not only DBT or psychoanalytical: Cognitive-Analytical Therapy (TCA) (Chanen et al., 2008; Ryle & Golynkina 2000), SBT (Farrel, Shaw, & Webber, 2009; Giensen-Bloo et al., 2006; Nadort et., al 2009), CBT (Davidson et al., 2006) and a combination of DBT and SBT (Leppänen, Hakko, Sintonen, & Lindeman, 2016). With regards to CAT, Chanen et al. (2008) did not find differences between groups at the level of parasuicidal behaviors or the diagnostic criteria of BPD, the only significant difference between CAT and the control group was in the externalizing of the psychopathology. In the study by Ryle & Golynkina (2000) only half of the sample failed to meet the diagnostic criteria for BPD. The three studies cited above that evaluate the efficacy of SBT showed a significant decrease in borderline symptoms and general psychopathology, and an improvement in overall functionality. With regard to CBT, only one clinical trial was found that obtained significant differences from the control group in anxiety-state and dysfunctional beliefs but not at the level of suicide attempts, hospitalizations, use of emergency services, trait anxiety, depression, interpersonal functioning, or quality of life. Finally, Leppänen, Hakko, Sintonen, & Lindeman (2016), combining elements of DBT and SBT, obtained significant improvements in impulsivity, paranoid and dissociative ideation, quality of life, self-injurious behaviors and variables related to suicide.

DISCUSSION

From these results the first thing we can affirm is that, in general terms, all of these psychotherapies seem to obtain significant improvements at the clinical level. Dialectical Behavioral Therapy, Schema-Based Therapy, Mentalization-Based Therapy, Transfer-Focused Therapy, Hobson's Conversational Therapy, and Cognitive Analytic Therapy have all demonstrated significant improvements, although the most empirically validated ones are CBT and MBT. However, there are very few studies that compare the efficacy of the different

TABLE 3
EFFECTIVENESS STUDIES OF OTHER PSYCHOTHERAPIES

Reference	N	Study characteristics	Therapeutic Mode	Measuring instruments	Effectiveness results
Ryle & Golynkina (2000)	16 F 11 M	NRCT.No CG.CAT	I	BDI, SCL-90-R, IIP, Social Questionnaire (SQ).	At the end of the intervention, patients were classified into two groups, depending on whether there was improvement or not. The group that had improved (N = 14) no longer met the diagnostic criteria for BPD. The group in which there was no improvement (N = 13) was divided into two subgroups, "uncertain" (n = 7) and "no change" (n = 6).
Davidson et al., (2006)	106	RCTCG (TAU) CBT	I	Acts of Deliberate Self-Harm Inventory (ADSHI), BDI, STAI, BSI, Social Functioning Questionnaire (SFQ), Young Schema Questionnaire (YSQ), Working Alliance Inventory (WAI).	CBT + TAU showed better results than TAU for dysfunctional beliefs and anxiety state. There were no significant differences in suicide attempts, hospitalizations, use of emergency services, anxiety-trait, depression, interpersonal functioning, or quality of life.
Giensen-Bloo et al., (2006)	80 F 6 M	RCTCG (TFT) SBT	I	BPDSI-IV, Dissociative Experiences Scale (DES), Dutch Screening List for Attention Deficit Hyperactivity Disorder for Adults.	SBT was superior to TFT in the reduction of borderline symptomatology and general psychopathology. Both groups significantly reduced borderline symptoms, general psychopathology, and increased the individuals' quality of life.
Chanen et al., (2008)	78	RCTCG (standard therapy)CAT	I	Youth Self-Report (YSR), Young Adult Self-Report (YASR), SCID–II, Social and Occupational Functioning Assessment Scale (SOFAS), SCID-II.	The CAT group showed significant differences in the variable externalizing of psychopathology. There were no differences between the groups at the level of parasuicidal behaviors or scores on diagnostic criteria of BPD.
Nadort et., al (2009)	60 F 2 M	RCT.CG (SBT)SBT+telephone therapy.	I	BPDSI-IV, SCL-90, World Health Quality of Life Questionnaire (WHOQOL), EuroQOL, EQ-5D, YSQ.	Decreased severity of borderline symptoms and general psychopathology in both groups. There were no inter-group differences in any variable.
Farrel, Shaw & Webber (2009)	28 F	RCTCG (TAU) SBT	G	BSI, SCL-90, Diagnostic Interview for Borderline Personality Disorder (DIB-R), GAFS.	The SBT group showed improvements in borderline symptomatology, general psychopathology and overall functioning. In the TAU group there was no improvement in any variable.
Leppänen, Hakko, Sintonen & Lindeman (2015)	44 F 7 M	RCTCG (TAU). DBT+SBT	G+I	BPDSI-IV, Health Related Quality of Life.	The combination of DBT+SBT shows a significant improvement in impulsivity, paranoid and dissociative ideation, quality of life and variables related to suicide.

Notes: N (F=Female; M=Male), Type of Study (RCT= Randomized Clinical Trial; NRCT=Non-Randomized Clinical Trial; LS= Longitudinal Study), CG (TAU=Treatment as usual; Therapeutic Mode (G=Group; I=Individual; G+I=Group and Individual

therapies, making it difficult to know exactly which therapy is most effective and on what it is most effective. For example, Clarkin, Levy, Lenzenwerger, and Kernberg (2007) compared the efficacy of DBT and TFT and the results showed that DBT obtained an improvement in 5 of the 12 variables analyzed (depression, anxiety, overall functioning, suicidal behaviors, and social adjustment), whereas TFT did so in 10 out of 12 (the same as those with DBT plus anger, impulsivity, irritability, and verbal and direct aggressiveness). Giensen-Bloo et al. (2006) compared TFT and SBT, finding that, although both significantly reduced borderline symptoms, and general psychopathology, and increased the participants' quality of life, SBT was better at reducing borderline symptomatology and general psychopathology.

From here, would it be correct to conclude or assume that TFT is superior to DBT and that TBE is in turn more effective than TFT? Firstly, it would be unwise to draw general conclusions from only two studies, and secondly, the role of the psychologist in the therapy must be borne in mind. It is not only important which type of psychotherapy is used but also who is practising it. It should be noted that the study by Clarkin, et al., (2007) was carried out by a team of TFT experts and the study by Giensen-Bloo et al. (2006) was carried out by experts in SBT. By saying this, we do not wish to question the validity of the results, but only to point out that psychotherapies are means for channeling the abilities of the practitioner, and each psychologist, due to their own way of understanding the human being, will feel more comfortable with one therapy or another. Therefore, it is not surprising that the TFT experts obtain better results with TFT than with DBT. So what is interesting, perhaps, is not so much to analyze which therapy is more effective but rather what does each psychotherapy offer that is new and clearly effective to the treatment. Through this study we seek to identify elements that are effective for different dimensions of BPD in order to take them into account when treating patients.

TDC has been shown to be effective in the reduction of autolytic and self-injurious behaviors, in general psychopathology, global functioning, depression, and anxiety. Psychoanalytical therapies such as TFT, MBT, and HCT have been shown to be effective in self-injurious and self-harming behaviors, general psychopathology, overall functioning, mood, depression, anxiety, and irritability. DBT seems to have more incidence on self-mutilating behaviors whereas psychoanalytic psychotherapies have more on variables of emotional regulation. With regards to SBT, the few studies that have been carried out show an improvement in general psychopathology, global functioning, and in borderline symptomatology.

These results can hardly lead us to conclude which psychotherapy is most effective in the treatment of BPD, but they can help to identify the variables in which each of the studied therapeutic models have a higher incidence, so we can understand which elements are essential in the treatment of BPD. To do this it would be necessary to interpret the results from a not strictly quantitative prism, but rather they should be valued as a tool for understanding and integrating useful elements that help channel the psychologist's skills towards better results. Therefore, effective psychotherapy for BPD should include some *a priori* essential ingredients such as the modification of mental schema, mentalization, validation, and evaluation of the individual before attempting any change.

However, despite the recognition of the importance of the lack of emotional regulation skills in BPD, the results obtained in these variables are not entirely satisfactory. It is only recently that we have begun to talk about emotional intelligence and there are still few studies that show the relationship between the presence and severity of BPD with low EI. It seems that it would be important to include ingredients that foster the development of emotional intelligence in the treatment of this disorder (Gardner, Qualter, & Tremblay, 2010; Lizeretti, Extremera, & Rodríguez, 2012; Peter et al., 2013).

Another point to consider is the viability of the therapies mentioned in the public health system. Most of the studies reviewed included between two and three hours of weekly psychotherapy, individually and in groups, for more than one year. Manualized DBT (Table 1) consists of one hour of individual therapy and two hours of weekly group psychotherapy, which amounts to three hours of psychotherapy per week for one year. In MBT (Table 2), the intervention was carried out over between two and a half hours (Bateman & Fonagy, 2001; Bateman & Fonagy, 2009) and six hours per week (Bateman & Fonagy, 1999), including individual and group sessions for 18 months. Thus, even though such psychotherapies have been shown to be efficacious, their efficiency is relative, and it would be of interest if future studies considered both the efficacy and the efficiency of psychotherapies for BPD.

Finally, as limitations of this review, it should be noted that there is a certain lack of methodological heterogeneity in the studies analyzed at the level of the evaluation instruments. Although the same constructs are usually measured, the tests used are very different, which makes it difficult to compare the efficacy between different therapies and limits the meta-analysis. Finally, we must note that most of the studies included in this review used "treatment as usual" as a control group. The nature of this control group is relatively disparate among the studies and can range from private treatment to outpatient treatment, from one visit per month to one per week, and even in some cases it can involve any type of treatment, whether psychological or not.

AUTHOR DISCLOSURE STATEMENTS

No competing interests exist.

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