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BORDERLINE PERSONALITY DISORDER: UPDATES ON TREATMENT

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Abstract: Borderline personality disorder (BPD) is a psychiatric condition characterized by emotional instability, impulsivity, self-destructive behaviour and dysfunctional interpersonal relationship patterns. With a high prevalence in clinical settings, BPD is often associated with comorbidities such as depression, anxiety disorders and substance use. This literature review aims to analyze the most recent updates on the clinical management of the disorder, with an emphasis on psychotherapeutic interventions and limiting the use of pharmacotherapy. The evidence shows that psychotherapy remains the first-line treatment, with emphasis on approaches such as dialectical behaviour therapy (DBT), mentalization-based therapy (MBT), schema therapy and transference-focused psychotherapy (TFP). On the other hand, the use of psychotropic drugs remains controversial and should be restricted to severe comorbid symptoms. New perspectives include the development of digital therapies, early interventions and personalized treatments. The study reinforces the need to expand access to evidence-based therapies, train professionals and combat the stigma that still surrounds the diagnosis, promoting comprehensive and humanized care for individuals with BPD.

INTRODUCTION

Borderline personality disorder (BPD) is a complex and challenging psychiatric condition characterized by a persistent pattern of instability in interpersonal relationships, self-image and emotional regulation, often associated with impulsivity, self-injurious behaviour and suicidal ideation (Leichsenring et al., 2024; Mendez-Miller; Naccarato; Radico, 2022) Since its inclusion in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM--III) in 1980, the diagnostic criteria for BPD have remained relatively stable until DSM-5, reflecting the persistent difficulty in its clinical

characterization and the therapeutic challenges that the disorder imposes. (Leichsenring et al., 2024)

The age of onset of BPD varies, usually manifesting in early adulthood, and its form of presentation can change according to age group, such as affective instability and irritation in relation to self-image in adolescents and depressive symptoms and somatic complaints in older patients (Leichsenring et al., 2024).

Studies show that the lifetime prevalence of BPD in the general population varies between 0.7% and 2.7%, but its frequency can reach up to 22% in psychiatric inpatient settings, which reflects its clinical severity and the high degree of associated comorbidities, such as depressive disorders, substance use disorders, post-traumatic stress disorder (PTSD), bipolar disorder and eating disorders. (Leichsenring et al., 2024; Mendez-Miller; Naccarato; Radico, 2022) The high incidence of suicidal behavior and self-harm, as well as the frequent use of health services, are aspects that make the clinical management of BPD a priority issue in contemporary psychiatry.

According to the 2014 edition of the DSM-5®, BPD is classified by five (or more) of the following diagnostic criteria:

1. desperate efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self-harm behavior covered by Criterion 5.)

2. A pattern of unstable and intense interpersonal relationships characterized by alternating extremes of idealization and devaluation.

3. Identity disturbance: marked and persistent instability of self-image or self-perception.

4. Impulsivity in at least two potentially self-destructive areas (e.g., spending, sex, substance abuse, irresponsible driving, binge eating). (Note: Do not include suicidal or self-harm behavior covered by Criterion 5.)

5. Recurrence of suicidal or self-mutilating behavior, gestures or threats.

6. Affective instability due to marked mood reactivity (e.g. episodic dysphoria, irritability or intense anxiety usually lasting a few hours and only rarely more than a few days).

7. Chronic feelings of emptiness.

8. Intense and inappropriate anger or difficulty controlling it (e.g. frequent displays of irritation, constant rage, recurrent physical fights).

9. Transient paranoid ideation associated with stress or intense dissociative symptoms.

The etiology of the disorder involves a complex interaction between genetic and environmental factors, especially adverse childhood experiences such as neglect, physical or emotional abuse, which contribute to alterations in neurobiological circuits related to affective regulation and impulsivity. (Leichsenring et al., 2024) However, despite advances in understanding these mechanisms, the neurobiological underpinnings of BPD are still not fully understood.

It is estimated that between 8% and 10% of individuals with this profile commit suicide. Self-injurious behavior, such as cutting or burning oneself, as well as suicide threats and attempts, are highly prevalent. Recurrent suicidal ideation is often the main motivator for seeking psychological or psychiatric care. Such self-destructive behaviors are largely triggered by situations perceived as imminent abandonment, interpersonal rejection or external demands requiring greater autonomy or responsibility (DSM-5®, 2014).

Psychotherapy is considered the first-line treatment, with robust evidence for approaches such as dialectical behaviour therapy (DBT), mentalization-based therapy (MBCT), transference-focused therapy and schema therapy. Randomized clinical trials and meta-analyses show that these interventions significantly reduce the severity of core BPD symptoms and the risks associated with suicidal behaviour. (Leichsenring et al., 2024; Setkowski et al., 2023) However, there is no

consensus on the superiority of one technique over the others, and approximately half of patients do not respond satisfactorily to psychotherapy treatment alone, which reinforces the need for more personalized therapeutic strategies. (Setkowski et al., 2023)

In contrast, there is insufficient evidence to recommend the routine use of psychotropic medication to treat the core features of BPD. Pharmacotherapy can be considered only for specific comorbid symptoms, such as severe anxiety, depression or dissociative symptoms, always in association with psychotherapeutic support (Leichsenring et al., 2024; Mendez--Miller; Naccarato; Radico, 2022).

Other personality disorders can present clinical manifestations that overlap with those of borderline personality disorder, which can create diagnostic difficulties. Therefore, diagnostic differentiation should be based on identifying the specific core characteristics of each disorder, considering their distinct cognitive, affective, interpersonal and behavioral patterns (DSM-5®, 2014).

However, when an individual presents personality traits that meet the diagnostic criteria for one or more personality disorders concurrently with borderline personality disorder, it is clinically appropriate for all diagnoses to be assigned, provided that each set of criteria is fully met independently (DSM-5®, 2014).

Given the clinical complexity and significant social impact of BPD, early diagnosis and management are essential to reduce morbidity, patient suffering and costs to health systems.

Thus, this article aims to critically review recent updates in the clinical management of borderline personality disorder, exploring advances in psychotherapy, the limits of pharmacotherapy and future prospects for more effective and personalized interventions.

METHODOLOGY

This research is a literature review that aims to gather and analyze the latest evidence on the clinical management of borderline personality disorder, based on the updates available in the scientific literature. The search was carried out in a structured way in the PubMed database, covering publications from the last five years. The following terms were used as descriptors: "Borderline Personality Disorder", "Treatment" and "Diagnosis", combined in order to ensure a broad and specific selection of studies related to the topic.

We included articles available in their entirety that directly or indirectly addressed diagnostic and therapeutic strategies for borderline personality disorder. Publications in different languages were accepted, as long as they were accessible, with methodological coherence, scientific relevance and thematic pertinence. Original studies, narrative reviews and update articles were considered eligible. Exclusion criteria included duplicate publications, studies outside the scope of the research and articles not accessible on the PubMed database.

RESULTS AND DISCUSSION

Analysis of the current evidence on the clinical management of borderline personality disorder (BPD) shows that, despite the widespread prescription of psychotropic drugs - received by up to 96% of patients seeking treatment - there is no consistent scientific support for the efficacy of any drug class in the core manifestations of the disorder. Polypharmacy, although common, is problematic: around 19% of patients use four or more psychotropic drugs simultaneously, often without a precise indication or support from robust clinical studies (Leichsenring et al., 2024; Mendez-Miller; Naccarato; Radico, 2022).

Pharmacotherapy has a limited role and is only indicated for discrete and severe comorbid symptoms, such as severe depression, transient psychotic symptoms or intense anxiety. Even in these situations, use should be brief and aimed at crisis management, respecting the principles of clinical prudence and risk minimization, especially considering the high prevalence of concomitant addictive disorders in BPD. (Leichsenring et al., 2024) Medications such as zolpidem or eszopiclone can be considered for refractory insomnia, but always with caution and for a limited time, due to the risk of dependence. (Mendez-Miller; Naccarato; Radico, 2022) In general, the available randomized clinical studies are scarce, especially in the context of comorbidities, which limits the clinical applicability of the available evidence.

On the other hand, psychotherapy remains the treatment of choice, with strong empirical support in controlled clinical studies and meta-analyses. Structured approaches such as dialectical behaviour therapy (DBT), mentalization-based therapy (MBCT), transference-focused psychotherapy (TFP) and schema therapy (ST) have demonstrated significant efficacy in reducing the core symptoms of BPD, improving global functioning and reducing suicidal behaviour (Leichsenring et al., 2024; Mendez-Miller; Naccarato; Radico, 2022) However, its large-scale implementation remains limited, especially in public health services or in regions with a shortage of trained professionals.

Characteristics such as emotional instability, impulsivity and intense interpersonal relationships tend to be maintained throughout the life cycle. However, studies indicate that individuals participating in structured therapeutic interventions often show significant clinical progress, with the first signs of improvement usually manifesting themselves within the first year of follow-up (DSM-5®, 2014).

Promising evidence has been observed for generalist models of psychotherapeutic intervention, which integrate principles from specialized therapies and can be applied by experienced clinicians with adequate supervision, even if they do not have formal training in specific approaches. By serving as control groups in comparative studies, these models have revealed relevant therapeutic effects, although greater methodological standardization and future research are needed to confirm their equivalence to traditional specialist models (Leichsenring et al., 2024).

The findings presented reaffirm the centrality of psychotherapy in the treatment of borderline personality disorder, highlighting it as the first-line intervention, according to the most recent clinical guidelines. The diversity of validated psychotherapeutic approaches and the growth of adaptive models broaden the therapeutic range and offer more accessible and viable treatment possibilities, especially in clinical contexts with structural limitations. Even so, the lack of uniformity in the application of evidence-based models and the deficit of specific training among professionals are significant barriers to effective care.

Pharmacotherapy, on the other hand, is an adjunctive resource and should not be considered the main approach in the treatment of BPD. The common practice of psychopharmacological prescription, even in the absence of regulatory approval or conclusive evidence of efficacy, raises ethical and clinical concerns. The high prevalence of polypharmacy among patients with BPD highlights a pattern of treatment that, in addition to being poorly supported, can intensify the risks related to dependence, adverse effects and drug interactions. (Mendez-Miller; Naccarato; Radico, 2022) Medication should therefore be restricted to clear and well-defined comorbid conditions, always in association with psychotherapeutic interventions.

In addition, difficulties in early diagnosis, the stigma associated with the disorder and the scarcity of specialized resources perpetuate a scenario of under-treatment and prolonged suffering for patients. It is remarkable that many individuals with BPD take years to seek professional help, and when they do, they often face resistance or discrimination in the health services themselves. (Leichsenring et al., 2024) This reality poses a challenge not only clinically, but also ethically and institutionally, requiring investments in professional training, awareness campaigns and public policies that favor access to qualified care.

The data also points to the need to expand clinical research into intervention strategies in crisis situations, such as episodes of self-harm, suicidal ideation or dissociative decompensation. The lack of randomized clinical trials aimed at this specific context represents a significant gap in the literature. Furthermore, the adaptation of treatments to the comorbidities frequently found in BPD - such as eating disorders, drug addiction and mood disorders - is a field that requires more robust studies and more precise methodological designs.

Finally, it is important to include the family and support network in the therapeutic plan, considering the emotional burden often imposed on caregivers. Psychoeducational interventions aimed at family members can significantly contribute to treatment adherence and the reduction of relapses, promoting a more stable and welcoming relational environment for the patient (Leichsenring et al., 2024).

Family participation is also part of the assessment. Family history is of clinical relevance, since borderline personality disorder has an occurrence rate approximately five times higher among first-degree biological relatives of diagnosed individuals, compared to the general population. In addition, there is a significant increase in familial predisposition to substance use disorders, antisocial personality disorder, as well as mood spectrum disorders such as major depression and bipolar disorder (DSM-5®, 2014).

The field of borderline personality disorder research and treatment has several promising future prospects, all of which focus on improving diagnostic accuracy, treatment efficacy and accessibility. One of the key areas is research into the neurobiological underpinnings of BPD; advanced neuroimaging methods are used to identify changes in specific brain areas and pathways that are responsible for emotional dysregulation and impulsivity (ALGHAMDI et al., 2023). A deeper understanding of the mechanisms could result in more targeted medication approaches, although the efficacy of medications on the main symptoms of BPD remains strongly contested (GUNDERSON et al., 2024; STAHL et al., 2021). Another significant trend is the development of digital therapies and technology-assisted means of treatment. The main goals of digital therapy are to make evidence-based psychotherapy more accessible and easier to expand; it could even be reached by people in remote regions or who could not seek treatment offline (KEY et al., 2025). Research into personalized treatment approaches is also gaining momentum; with the aim of finding out whether there are predictions that the outcomes of psychotherapy modalities are possible according to certain patient characteristics or a unique symptom profile (GUNDERSON et al., 2024). In addition, there is also great interest in early intervention, especially in adolescents, since it is common for BPD to manifest during this period of development (ALGHAMDI et al., 2023). Early identification and treatment of BPD has the potential to significantly alter the course of the disorder, with the possibility of preventing chronic impairment and improving long-term outcomes. In this sense, ongoing efforts to reduce the stigma associated with the disorder and increase public and

professional understanding are of paramount importance in order to create an environment conducive to the improvement of individuals who seek help and ensure that they receive appropriate care.

Despite the remarkable progress in understanding and treating borderline personality disorder, several challenges remain, highlighting critical areas for future research and clinical innovation. One of the main challenges in this process is ensuring the accessibility and availability of evidence-based psychotherapies. Although treatments such as Dialectical Behavior Therapy (DBT), Mentalization-Based Treatment (MBT), Transference-Focused Psychotherapy (TFP) and schema therapy have shown efficacy, their highly specialized nature means that they are not easily available, especially in poor areas of the world or for people with limited purchasing power (GUNDERSON et al., 2024). Filling this gap will require innovative delivery models, including teletherapy and digital platforms, as well as more training for mental health professionals. Another challenging issue is the high rate of comorbidity associated with BPD. The relatively high comorbidity with depression, anxiety, substance abuse and eating disorders often requires an integrated approach, as it is important to address several problems simultaneously (GUNDERSON et al., 2024). More research is needed to understand the complicated interaction of BPD with these comorbid disorders in order to develop more effective integrated treatment protocols. Finally, BPD still has a considerable percentage of patients who do not achieve remission or show persistent symptoms, highlighting the need for greater treatment efficacy (GUNDERSON et al., 2024). This could include improving existing therapies, developing new interventions or even investigating precision treatment based on a patient's individual characteristics and molecular indicators. Finally, stigma is another significant barrier to care, leading to late diagnosis, reluctance to seek care and past trauma in the healthcare system (ALGHAMDI et al., 2023). Continued efforts to raise awareness of BPD among the public and healthcare professionals, highlighting its treatability, as well as the importance of compassionate care, are extremely important to eliminate these barriers and ensure that individuals with BPD receive the support and treatment they need and deserve.

In summary, the clinical management of BPD requires a multidimensional and evidence-based approach, in which psychotherapy plays a central role, and pharmacotherapy should be used sparingly and with strict criteria. Improving clinical strategies, reducing stigma and increasing access to specialized therapies are essential elements in transforming the landscape of care for borderline patients, promoting greater therapeutic efficacy and a better quality of life.

CONCLUSION

Borderline personality disorder represents one of the greatest contemporary mental health challenges, not only because of the complexity of its clinical presentation, but also because of the structural and social barriers that hinder access to adequate treatment. The evidence reinforces that structured psychotherapy should be considered the pillar of therapeutic management, while pharmacotherapy should be used with discretion and only in specific comorbid cases. The high rate of polypharmacy and the lack of effective drug treatments for the core symptoms of the disorder highlight the urgency of a more rational, evidence-based and patient-centered clinical approach. Advances in digital therapies, the use of early intervention technologies and ongoing efforts to personalize treatment offer promising prospects for the future. Even so, persistent stigma, a shortage of trained pro-

fessionals and the difficulty of early diagnosis remain significant obstacles. It is therefore essential to invest in education, public policies and social awareness in order to guarantee effective, ethical and accessible care for people with BPD, promoting their psychosocial rehabilitation and quality of life.

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