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Contributions of dialectical behavior therapy (DBT) in borderline personality disorder (TPB)

Contributions of dialectical behavior therapy (DBT) to borderline personality disorder (BPD)

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SUMMARY

Epidemiological studies estimate that between 10% and 13% of the population meets criteria for personality disorders. The most severe forms, such as borderline personality disorder, marked by intense impairment in interpersonal relationships, have a prevalence of approximately 4%. This study aimed to investigate the contributions of Dialectical Behavior Therapy (DBT) in the treatment of Borderline Personality Disorder (BPD), particularly with regard to improving quality of life and its effectiveness in reducing self-destructive behaviors, impulsivity, emotional instability, and improving interpersonal relationships.

Using a literature review methodology, scientific articles from 2000 to 2025 from databases such as SciELO and online psychology journals were analyzed to identify the effects of DBT on emotional regulation and crisis management in individuals with this type of disorder. The results identified significant improvements through the development of new behavioral skills that contribute to emotional regulation, impulse control, interpersonal effectiveness, and distress tolerance.

Keywords: Emotional Dysregulation. Intervention. Dialectical Behavior Therapy.
Borderline Personality Disorder. Skills Training.

ABSTRACT

Epidemiological studies estimate that between 10% and 13% of the population meets the criteria for personality disorders. The most severe forms, such as borderline personality disorder, marked by intense impairments in interpersonal relationships, have a prevalence of approximately 4%. The present study aimed to investigate the contributions of Dialectical Behavior Therapy (DBT) in the treatment of Borderline Personality Disorder (BPD), especially with regard to improving quality of life and effectiveness in reducing self-destructive behaviors, impulsivity, emotional instability, and improving interpersonal relationships. Using a literature review methodology, scientific articles from 2000 to 2025 were analyzed from databases such as SciELO and electronic journals in psychology to identify the effects of DBT on emotional regulation and control of emotional crises in individuals with this type of disorder. The results identified significant improvements through the development of new behavioral skills that contribute to emotional regulation, impulse control, interpersonal effectiveness, and tolerance to discomfort.

Keywords: Borderline Personality Disorder. Dialectical Behavior Therapy. Emotional Dysregulation. Intervention. Skills Training.

1. INTRODUCTION

Borderline Personality Disorder (BPD) is characterized by a persistent pattern of instability in interpersonal relationships, self-image, affections, chronic feelings of emptiness, fear of abandonment and heightened impulsivity. This intense emotional instability and difficulty in regulating emotions often lead individuals to self-destructive behaviors, including self-harm and suicide attempts as defined in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition DSM-5 *(American Psychiatric Association* - APA, 2014).

Its origin is multifactorial, involving the interaction of genetic aspects and experiences adverse childhood events, such as neglect, invalidation, and abuse. The factors mentioned contribute to emotional dysregulation and impulsivity, triggering patterns of behavioral dysregulation and psychosocial difficulties (Lieb *et* al., 2004). This vicious cycle further reinforces instability emotional and impulsivity, resulting in cognitive dysfunctions that affect the affective, behavioral and, consequently, interpersonal relationships.

The DSM-5 provides information that the first signs of BPD generally appear in adolescence or early adulthood, with symptoms manifesting with greater intensity by around the age of 18 to 25. However, during childhood, certain personality traits that can evolve into this disorder can be observed, as well as the presence of impulsivity, emotional instability and risk behaviors in adolescence may be strongly associated with their development in adult life.

Research indicates that these predisposing factors are often related to emergence of intense emotional suffering and dysfunctional behaviors, impacting negatively affect the quality of life of these individuals (ZANARINI *et* al., 2006; WINOGRAD, COHEN and CHEN, 2008; and JOHNSON *et* al., 2000). These findings highlight the relevance of preventive interventions in youth, focusing on emotional regulation and management impulsive behaviors.

> It is estimated that approximately 10 to 13% of the general population, when investigated with epidemiological instruments, meets the diagnostic criteria for personality disorder. There is a prevalence of approximately 4% for the most severe forms of personality disorder (including borderline disorder, sociopathy, and other personality disorders with intense disturbance in interpersonal relationships...) (DALGALARRONDO, 2019, p. 281).

Dialectical Behavioral Therapy (DBT), the reference model used in this work, is based on a biosocial and dialectical theory and uses many principles and procedures of cognitive and behavioral therapies with acceptance and change practices. Developed from in the 1970s by American psychologist Marsha Linehan, initially to treat patients with chronic suicidal behavior, DBT focuses on skills development and training behavioral, such as emotional regulation, impulse control, distress tolerance and interpersonal effectiveness.

The alarming rates of suicide and self-harm, along with great emotional instability that patients face often require hospitalizations. However, these hospitalizations do not always guarantee lasting improvements in the health of individuals (CHAPMAN and GRATZ, 2007).

Therefore, it is essential to investigate how these symptoms affect predisposing individuals or already diagnosed with BPD and seek effective therapeutic methods, aiming to improve both practice clinical and applications for this population that faces great challenges.

Given its complexity, with regard to the challenges experienced by those with this disorder and regarding evidence-based treatment, we sought to investigate how the effectiveness of TCD contributes to improving the quality of life of patients, reducing symptoms and development of skills. The central question that guided this research was “What are the contributions of DBT in the treatment of BPD and how does it impact patients’ lives?”

The main hypothesis of the research suggests that the systematic application of Therapy Dialectical Behavioral Therapy (DBT) results in helping individuals identify and modify their maladaptive behavioral patterns, emotional instability, interpersonal relationships and in reducing self-destructive behaviors. Based on the available evidence, it is believed if in the potential reduction of crisis episodes and improvement in individuals' interpersonal relationships with Borderline Personality Disorder (BPD).

The general objective was to analyze the contributions of DBT in the treatment of BPD and its implications for significantly improving patients' quality of life. Some of the others objectives sought during the research were: to observe in scientific articles what the results were achieved by applying DBT to reduce symptoms of emotional instability; decrease in self-destructive behaviors and episodes of emotional crisis; development of skills emotional regulation; improvement in interpersonal relationships and reduction of comorbidities associated with BPD, such as anxiety and depression.

The justification for carrying out this research is the clinical and social relevance of improve the treatment of complex disorders such as BPD by expanding the knowledge base about therapeutic approaches that have been proven to have a positive impact on patients' lives.

The relevance of research in the field of Psychology is due to the need to explore evidence-based interventions, such as DBT, that contribute significantly to practice clinical and treatment of personality disorders. This research offers theoretical and practical for professionals who work with highly complex patients, expanding the field of performance of clinical psychology.

2 THEORETICAL FRAMEWORK

According to the DSM-5 (APA, 2014), personality disorders are characterized by persistent patterns of behavior, cognition, and inner experience that deviate from significant difference in the individual's cultural expectations. These dysfunctional patterns are inflexible, are present in various situations and lead to social, occupational or other suffering or harm other important areas of the individual's life.

Specifically, Borderline Personality Disorder (BPD) is classified in the DSM-5 by code 301.83 (F60.3), as a Cluster B Personality Disorder. Individuals with BPD are characterized by a pattern of instability in emotions and interpersonal relationships, in self-image and affect and marked impulsivity. This disorder manifests itself in efforts desperate to avoid real or imagined abandonment, in an unstable self-image, in self-destructive behaviors and episodes of intense emotional instability (APA, 2014).

Widely recognized for the severity of emotional and behavioral symptoms, associated with high rates of suicide, self-harming behaviors, and chronic relationship difficulties interpersonal, patients with Borderline Personality Disorder (BPD) often have difficulties in emotional learning, resulting from invalidating environments experienced during childhood (LYNCH *et* al., 2007). These environments cause individuals to ignore or distort their own emotions and the emotional expression of others (MCMAIN *et* al., 2001).

> As a result, many do not develop the skills to understand, name, regulate, or tolerate their emotional responses, nor to effectively solve problems. Instead, they tend to oscillate between inhibiting and expressing their emotions in extreme ways (CRO-WELL, BEAUCHAINE AND LINEHAN, 2009, p. 495 - 510).

It is often associated with comorbidities such as major depression, mood disorders, anxiety, substance abuse and eating disorders, which contribute to the intensification of core symptoms of emotional dysregulation, impulsivity, and self-injurious behaviors. These comorbidities not only aggravate psychological suffering but also make prognosis and treatment difficult adherence to treatment (BATEMAN and FONAGY, 2016).

According to the American Psychiatric Association (APA, 2014), comorbidities associated such as agoraphobia, for example, are present in approximately 50% of individuals diagnosed with BPD. In addition, bulimia nervosa, another highly prevalent disorder, affects about 25% of cases, as pointed out by Sansone and Levitt (2002).

The presence of comorbid anxiety can intensify emotional instability and impulsivity, core features of BPD, while eating disorders can represent an additional challenge to treatment, due to the high risk of behaviors self-harm and possible resistance to therapeutic intervention. Thus, the coexistence of these conditions demands therapeutic approaches that aim for greater effectiveness in emotional stabilization and adherence to treatment.

Furthermore, BPD is related to significant impacts on social functioning and occupational, leading to difficulties in maintaining interpersonal bonds, low stability in employment and academic losses, contributing to a high level of social disability and professional (LIEB *et* al., 2004).

Longitudinal studies suggest that the presence of impulsivity, emotional instability and risk behaviors in adolescence may be strongly associated with the development of Borderline Personality Disorder (BPD) in adulthood. Research indicates that these factors predisposing factors are often related to the emergence of intense emotional distress and self-destructive behaviors, negatively impacting the quality of life of these individuals (ZANARINI *et* al., 2006; WINOGRAD, COHEN and CHEN, 2008; and JOHNSON *et* al., 2000). These findings highlight the relevance of preventive interventions in youth, with a focus on regulation emotional and in the management of impulsive behaviors.

Dialectical Behavior Therapy (DBT) is based on a biosocial model, understanding that BPD develops from the interaction between biological factors and environmental factors (social) throughout the person's development. The approach seeks to balance acceptance and change, offering emotional validation strategies while promoting crisis management skills, regulate emotions and improve interpersonal relationships by integrating dialectical philosophy, the idea of

that two seemingly opposing truths can coexist, such as accepting yourself and changing. This balance between acceptance and change is fundamental in DBT and aims to help patients recognize and deal with intense emotions, promoting both the modification of dysfunctional behaviors regarding the acceptance of your current experiences and emotions.

Treatment requires structured and long-term interventions due to its complexity of the clinical picture that is marked by emotional dysregulation, impulsivity and behaviors self-destructive (LINEHAN, 1993). The author emphasizes the need to establish an alliance consistent therapy with clear definition of the frequency of sessions and provision of support between sessions sessions, such as telephone contacts in crisis situations. Furthermore, it highlights the use of techniques specific management techniques, such as emotional validation, the development of regulatory skills emotional, distress tolerance strategies and interpersonal skills training, central elements in the Dialectical Behavior Therapy model, with the aim of promoting greater emotional stability and prevent discontinuation of treatment.

TCD includes training in skills modules that aim to provide the patient with strategies to deal with your emotions and interpersonal relationships in a more adaptive way. Among these modules, mindfulness stands out, which teaches patients to focus on the moment present, identifying, acknowledging and observing your thoughts and emotions without judgment. This technique promotes greater emotional awareness and reduces automatic reactivity to external stimuli (LINEHAN, 1993).

Another essential module of DBT is emotional validation, which consists of a therapeutic strategy aimed at recognizing and legitimizing the patient's internal experiences, demonstrating understanding and acceptance of their feelings and behaviors in the context of their life story. This approach contributes to strengthening the therapeutic alliance, reduces emotional distress and improves patient receptivity to clinical interventions (LINEHAN, 1993).

Developing emotional regulation skills is also a component TCD center. This training helps the patient identify, understand and modulate their emotional responses, including techniques to increase emotional awareness, reduce vulnerability to intense emotion and modify dysfunctional emotional patterns. Examples of these practices involve increasing behaviors that produce positive emotions and promoting a balanced lifestyle, minimizing risk factors such as sleep deprivation and substance abuse substances (LINEHAN, 1993).

Distress tolerance strategies are techniques aimed at helping the patient to face moments of intense suffering without resorting to impulsive behavior or self-destructive. DBT teaches specific coping skills for crisis situations, promoting acceptance and emotional survival. Among the techniques employed, the following stand out: STOP method (Stop, Breathe, Observe and Proceed with mindfulness), the use of distractions healthy, calming oneself through the five senses and the practice of acceptance (LINEHAN, 1993).

Interpersonal skills training is another essential aspect of treatment, because it helps the patient establish and maintain more effective and healthy relationships. DBT teaches strategies for assertiveness, limit setting, conflict resolution and preservation of self-esteem in social interactions. Linehan (1993) highlights the DEAR MAN protocol (Describe, Express, Affirm, Reinforce, Be Mindful, Appear Confident, and Negotiate) as a resource fundamental for assertive communication, allowing patients to make requests and set limits respectfully and effectively.

In addition to the techniques applied in session, DBT also includes support between sessions, such as structured telephone contact, allowing the patient to obtain guidance in moments crisis. This resource is essential for the generalization of skills learned in therapy to real-life situations, preventing relapses and reducing maladaptive behaviors (LINEHAN, 1993).

In the context of clinical practice, DBT stands out as an effective approach to patients who exhibit self-harming behavior and frequent emotional crises. This approach enables the patient to learn to deal with intense emotions and develop skills of confrontation, promoting a significant change in quality of life (LINEHAN, 2015). Therefore, maintaining treatment is essential to avoid relapses, as discontinuation therapy can compromise the progress achieved, increase the risk of self-harm and reinforce dysfunctional patterns of interpersonal relationships (BATEMAN; FONAGY, 2016).

Discontinuation of treatment is a significant risk for patients, as many have difficulties in maintaining therapeutic bonds and may interpret the discontinuity as a reinforcement of their beliefs of rejection and abandonment. Permanence in treatment is a determining factor for clinical improvement, as it allows the consolidation of acquired skills and relapse prevention (LIEB *et* al., 2004).

Thus, DBT is configured as an essential therapeutic approach for management of BPD, promoting effective strategies for emotional regulation, improvement of

interpersonal relationships and reduction of impulsive and self-destructive behaviors. Continuity of treatment is a critical factor for therapeutic success, ensuring that patients develop skills that help them build a more stable and functional life.

2. MATERIAL AND METHOD

This study consisted of a bibliographic review research, with a design exploratory and qualitative and quantitative approach. The integrative review allowed the synthesis of multiple relevant publications on a specific topic, offering a systematic analysis of the results obtained in previous research. The objective was to identify, gather and analyze productions scientific research related to the application of Dialectical Behavioral Therapy in the treatment of individuals diagnosed with Borderline Personality Disorder.

The research was developed in systematic stages, which included: defining the question guiding principle; establishing inclusion and exclusion criteria; searching for and selecting studies in databases; the analysis and categorization of the information collected; and the presentation of the results. The guiding question that guided the research was: “What is the scientific evidence about the management of DBT in the treatment of patients with BPD between the years 2000 and 2025?”

The study sample consisted of scientific articles published in peer-reviewed journals by peers. Data sources were sought in electronic databases recognized by the community scientific, such as Scientific Electronic Library Online (SciELO), PubMed and specific journals of area of Psychology.

Well-defined inclusion criteria were adopted: publications between the years were included 2000 and 2025, written in Portuguese, that directly address the application of TCD in patients diagnosed with BPD. The studies presented empirical data on the efficacy, management strategies and intervention results. On the other hand, publications that were not peer-reviewed, studies that dealt with other therapeutic approaches without focus main in TCD, articles in other languages, publications other than case studies and materials published before the year 2000.

The data collection process was carried out between January and March 2025. Initially, combined descriptors were used, such as “Emotional Dysregulation”, "Intervention", "Dialectical Behavior Therapy", "Borderline Personality Disorder",

"Skills Training" in accordance with the criteria established for advanced research in each database.

After selecting the articles, an exploratory reading of the abstracts was carried out to identify of relevance. Then, an analytical reading of the complete texts was carried out in order to extract the information relevant to the research question. The information was organized into four summaries, categorized according to the main aspects investigated: intervention strategies, results observed clinical findings, limitations identified in the studies and directions for future research.

Data analysis followed a qualitative approach, through the identification of patterns, convergences and divergences in the findings presented. In some cases, when studies presented quantitative data, relevant statistical results were highlighted, with emphasis on effectiveness of the strategies proposed by TCD in the management of patients with BPD.

The development of this bibliographic review provided an updated overview of the scientific production on the topic, allowing a critical understanding of advances and challenges related to the application of DBT in specific clinical contexts for BPD.

This work complies with ethical principles, respecting the dignity human, human rights and fundamental freedoms, recognizing the importance of freedom of scientific research and the benefits arising from scientific advances.

Bibliographic sources were used to support the theoretical foundation and contextualization of Borderline Personality Disorder (BPD), providing a comprehensive understanding of its definition, diagnosis and historical trajectory. The Manual Diagnostic and Statistical Manual of Mental Disorders DSM-5 (APA, 2014) constituted a reference central, for presenting the official diagnostic criteria for TPB and its classification in the systems current classifications. Furthermore, the works of Marsha Linehan (1993, 2015) on Therapy Dialectical Behavioral Studies (DBT) were instrumental in describing the principles and strategies this approach in the treatment of BPD. The practical guide prepared by Bohus and Reicherzer (2017) also proved to be relevant, as it offered accessible and applicable guidance to both patients as for family members who live with the disorder.

The studies analyzed allowed a deeper understanding of the Disorder of Borderline Personality Disorder (BPD) and its main therapeutic approaches, serving as a basis for the construction of the theoretical framework and for the formulation of the hypotheses of this work. The work of Cavalheiro and Melo (2016) explores the challenges inherent in the therapeutic relationship with patients borderline, with emphasis on strategies adopted within Dialectical Behavioral Therapy (DBT).

Dalgalarrondo (2019) contributes with a detailed description of the psychopathology of disorders mental disorders, including BPD and its clinical manifestations. These materials were fundamental for understand both the psychopathological aspects of the disorder and interventions based on evidence.

The materials that were used included case studies and applied research that offered data on interventions for patients with BPD, providing an analysis in-depth information on therapeutic results.

The data were collected, organized and analyzed qualitatively, based on criteria such as treatment effectiveness, symptom reduction and improvement in patients' quality of life.

For this research, the use of materials such as paper, printing, computers was foreseen, tablets, cell phones and books. These and other resources that were necessary were paid for by the researchers themselves. Initially, the research team expected to use resources previously acquired assets.

Table 1 – Case Studies

Title	Author / Year	Place of Publication	Website
Borderline personality disorder from an analytic-functional perspective	Sousa, ACA / 2003	Brazilian Journal of Behavioral Therapy and Cognitive	https://www.rbtcc.com.br/RBTCC/ar-ticle/view/76/65
Self-harm and suicidality in borderline personality disorder associated with paraphilia disorder: a case report	Tavares, TM; Orsin, M.; McBenedict, B.; Magnani, MH; Araújo, JC; Armada L. / 2025	Caribbean Journal of Social Sciences	https://www.revistacari-bena.com/ojs/index.php/rccs/arti-cle/view/4422/3089
The therapist-client relationship and borderline personality disorder	Cunha, OR; Vandenberghe L. / 2016	Brazilian Journal of Behavioral Therapy and Cognitive	https://rbtcc.com.br/RBTCC/arti-cle/download/833/461/3347

A case of borderline personality disorder treated in dialectical behavioral therapy	Gauer, BF / 2023	FT Magazine	https://revistaft.com.br/um-caso-de-transtorno-de-personalidade-border-line-atendido-em-terapia-comporta-mental-dialetica/
Consequences of borderline personality on adherence to chronic pain treatment	Macedo, BBD; Menezes, CNBB; Gomes, JMA; Baes, CVW; Juruena, MF / 2017	Journal of Humanities	https://ojs.unifor.br/rh/arti-cle/view/7476/5547

Source: Authors

The analysis procedure for the selected articles consisted of understanding and contextualization of the article with a careful reading to understand the clinical case presented, identify the clinical context and relevance of the case in the literature, verify the justification for the study and its contribution to the advancement of knowledge; evaluate the structure and quality of the report following criteria of clarity and objectivity, use of appropriate guidelines and presentation of clinical data; analyze the methodology used according to criteria of applied therapeutic methods and research on the presence of biases or omissions that could compromise the interpretation of the data; ethical considerations such as confirming the protection of patients' identities, compliance with privacy standards and assessment of compliance with ethical principles and publication guidelines scientific; identification of clinical implications such as reflection on the contributions of cases clinical for psychology, the discussion of the therapeutic approach adopted and the evaluation of applicability of findings to other clinical contexts; validation and conclusion of critical reflections on the robustness of the evidence presented, analysis of the coherence between the conclusions and the data discussed in the articles and the identification of possible limitations and suggestions for future research.

3. RESULTS AND DISCUSSION

In this section, the data obtained through the research carried out are presented, which were submitted to careful analysis. The interpretation of the results was conducted based on the reference previously established theoretical framework, enabling a coherent articulation between the empirical findings

and the contributions of specialized scientific literature. The discussion aimed to highlight the most significant elements emerging from the investigation, highlighting their theoretical implications and practices in the field of study.

Gender

In all cases analyzed in the present study, all patients presented female gender expression. This finding corroborates the epidemiological data described in the DSM-5 (APA, 2014), according to which approximately 75% of individuals diagnosed with borderline personality disorder are female. Although the DSM-5 recognizes the possibility of diagnosis in individuals of all genders, the data suggest a prevalence significantly higher among women, which may reflect psychosocial and biological factors.

Age range

Regarding age, the articles studied had women aged ranging from 27 to 34 years. According to the DSM-5 (APA, 2014) the first symptoms appear in adolescence, with greater intensity between the ages of 18 and 25, this being a critical period for treatment. After the age of 30, according to the DSM-5 (APA, 2014), there is a reduction in severity of symptoms, due to emotional maturity. In short, the participants in the studies here reported were at the end of the critical period for diagnosis and initiation of treatment, probably with milder symptoms.

Level of education

There is mention of the educational profile of some of the study participants. Three of them have higher education as in Sousa (2003), Macedo *et al* (2017) and Gauer (2023). In both first studies cited here the participants do not exercise their professions because of the comorbidities they face, while in the last study the participant has training and works his profession in addition to studying for his second degree in psychology. In the other articles, the participants' level of education was mentioned.

This data is in line with the literature, which indicates that, although some people with BPD to achieve high educational levels, the losses resulting from the disorder and its comorbidities often make it difficult to maintain occupational stability and professional development, generating high rates of incapacity in the workplace and in social relations (LIEB *et* al., 2004).

Family history

In none of the cases studied was there any mention of psychological disorders in the history family. In all cases, except in Cunha and Vandenberghe (2016), it was pointed out that the family had, in a negative way, a significant role in the lives of the participants, which made them express difficulties related to self-image, need for acceptance and behavior patterns dependents, as well as lack of emotional support and patterns of emotional instability that impact your relationships and are directly related to current symptoms of the Disorder of Borderline Personality.

This finding corroborates the evidence presented by LIEB *et al.* (2004), who highlight the influence of adverse childhood experiences—such as neglect, emotional invalidation, and abuse — as etiological factors relevant to the development of dysregulation patterns emotional, impulsivity, and distortions in self-perception. These psychological impairments favor the manifestation of maladaptive behaviors and accentuate difficulties psychosocial, culminating in cognitive dysfunctions that significantly compromise distinct spheres of the individual's overall functioning.

Sessions per week, treatment duration and session characteristics

Only three of the five studies analyzed provided information on the duration of psychotherapeutic treatment. In the study by Sousa (2003), the patient was followed by approximately two years, with weekly two-hour sessions, although the total number of meetings has not been specified. Cunha and Vandenberghe (2016) reported 22 meetings sessions, each lasting 50 minutes, without indicating the weekly frequency. In Macedo *et al.* (2017), the treatment lasted for approximately 21 months, with weekly 45-minute sessions, but, as with the others, it was not reported whether there was more than one appointment per week. The others two studies did not present data on follow-up time or number of sessions carried out.

In all cases, the service was individual and took place in person, except in Gauer (2023) the service began remotely and later moved to face-to-face modality. Only in Sousa (2003) was there an additional resource, the possibility of patient to call the therapist between sessions. In Cunha and Vandenberghe (2016) the service occurred with a therapist and a clinical supervisor, in Macedo *et al* (2017) the service occurred with a multidisciplinary team consisting of a doctor, psychologist, psychiatrist and neurologist. In In other studies, the sessions were conducted with only one therapist.

The lack of information in the case studies regarding the duration of treatment, frequency of sessions and the composition of professional teams represents a relevant limitation, especially in the context of psychotherapeutic intervention for individuals with Attention Deficit Disorder Borderline Personality Disorder (BPD). Considering the diagnostic complexity and the particularities of the clinical management of this disorder, it is essential to adopt adapted, structured and long-term. As Linehan (1993) highlights, BPD is characterized by chronic patterns of emotional dysregulation, impulsivity and self-injurious behaviors, therefore requiring a continuous and systematic therapeutic planning.

Initial Symptoms/Complaints

In the studies by Sousa (2003), Gauer (2023) and Macedo *et al.* (2017), the participants started the therapeutic process with diverse clinical complaints, not directly associated with the Disorder of Borderline Personality Disorder (BPD), such as agoraphobia, bulimia, and symptoms related to Depression Disorder. Attention Deficit Hyperactivity Disorder (ADHD) and chronic pain. These manifestations were identified and treated throughout the first sessions, and were subsequently understood as comorbidities associated with BPD. On the other hand, in the studies by Tavares *et al.* (2025) and Cunha and Vandenberghe (2016), the beginning of psychotherapeutic monitoring occurred from symptoms directly compatible with the diagnostic criteria for BPD, as described in the DSM-5 (APA, 2014), such as self-harm, suicidal ideation, risky sexual behaviors, anxiety, feeling of emptiness and aggressiveness.

It is also noteworthy that the DSM-5 (APA, 2014) mentions that, during adolescence, symptoms of intense emotional instability, impulsivity, difficulty in relationships and chronic feelings of emptiness. Between the ages of 18 and 25, the risk of behaviors increases self-destructive behaviors, self-harm, and suicide attempts. Thus, the behaviors described can be understood as persistent symptoms, since the age range studied was from 27 to 34 years.

Comorbidities

In the studies by Sousa (2003) and Macedo *et al.* (2017), the participants began the process therapeutic with clinical demands distinct from Borderline Personality Disorder (BPD). As pointed out by the APA (2014), it is common for BPD to occur in comorbidity with other disorders, which can make diagnosis and appropriate clinical management difficult.

The participant in Sousa's study (2003) was initially diagnosed with agoraphobia, classified as an anxiety disorder by the APA (2014) and frequently seen in

individuals with Borderline Personality Disorder, with an estimated prevalence of approximately 50% of cases. In addition, the patient reported episodes of bulimia nervosa, another comorbidity commonly associated with BPD, affecting approximately 25% of patients, as pointed out Sansone and Levitt (2002). The presence of anxiety disorders can intensify instability emotional and impulsivity characteristic of BPD, while eating disorders tend to hinder the therapeutic course, increasing the risk of self-harm behavior and contributing to resistance to treatment.

In the study by Macedo *et al.* (2017), the participant presented comorbidities fibromyalgia and major depressive disorder. Although there is no consistent evidence in the literature that establish a direct correlation between fibromyalgia and Borderline Personality Disorder (TPB), the concomitant presence of these conditions can intensify subjective distress and compromise adherence to treatment. Depression, in turn, is widely recognized as a frequent comorbidity in individuals with BPD, with more than 80% of them experiencing least one major depressive episode throughout life (Zanarini *et* al., 1998). The presence of depressive symptoms is often associated with greater severity of symptoms and increased risk of suicide, making clinical management even more challenging.

Interventions

Linehan (1993) highlights certain specific techniques as central elements of TCD in clinical interventions, such as emotional validation, development of communication skills, emotional regulation, distress tolerance strategies and skills training interpersonal, with the aim of promoting greater emotional stability.

Emotional regulation techniques focusing on impulse control, emotion regulation intense and strategies to avoid crises in conjunction with mindfulness were observed in the participants of Gauer (2023) and Macedo *et al* (2017), the latter being specifically intended to help manage chronic pain and impulsivity arising from Borderline.

Social skills and assertiveness training was mentioned in Sousa's cases (2003), Cunha and Vandenberghe (2016) and Gauer (2023) with different purposes: for the first participant was essential in dealing with her difficulty in saying "no", for the second participant was used to help her establish more stable relationships and, for the latter, to help her relate more authentically and reduce the fear of rejection.

Psychoeducation on Borderline Personality Disorder was applied in studies of Sousa (2003), Tavares *et al* (2025), Gauer (2023) and Macedo *et al* (2017) helping to explain the

disorder, in understanding the symptoms and, specifically for the participants of Gauer (2023) and Macedo *et al* (2017), was also used to discuss the impact of substance use and disorders associated with BPD, with the use of illicit substances being an aggravating factor for symptoms and treatment of BPD. In no case was family psychoeducation reported.

Pharmacological intervention was used in three of the five cases analyzed, through administration of different classes of psychotropic drugs, according to specific clinical needs of each participant.

In the study by Tavares *et al.* (2025), the patient was subjected to a drug regimen composed of fluoxetine, a selective serotonin reuptake inhibitor (SSRI); quetiapine, atypical antipsychotic with mood-stabilizing properties; and clonazepam, a benzodiazepine fast-acting with anxiolytic and sedative effects. The combination of these drugs created a plan therapeutic aimed at managing depressive and anxiety symptoms, mood stabilization, reduction of psychotic symptoms and improvement in sleep quality.

In Gauer's study (2023), pharmacotherapy included lithium, a classic mood stabilizer effectively preventing manic and depressive episodes, in association with escitalopram, also classified as an SSRI. This combination aimed to enhance the effects antidepressants, preventing depressive relapses and reducing the risk of suicide, especially in contexts marked by significant affective symptoms.

In turn, in the study by Macedo *et al.* (2017), the patient was medicated with fluoxetine, acting in the modulation of serotonergic neurotransmission, and flurazepam, benzodiazepine long-acting hypnotic with central nervous system depressant action. The therapeutic regimen proposed aimed to manage depressive symptoms and insomnia, also promoting the reduction anxiety and improved sleep patterns.

In addition to psychotherapeutic and pharmacological interventions, monitoring was observed systematic and prevention of risk behaviors in different clinical contexts. These behaviors included impulsivity and episodes of self-harm (Tavares *et* al., 2025), aggressive manifestations associated with interpersonal difficulties (Cunha & Vandenberghe, 2016) and abuse of psychoactive substances, combined with emotional impulsivity (Gauer, 2023). The strategies adopted in each case sought to contain immediate risks to the physical integrity of patients, as well as the reduction of recurring dysfunctional behavioral patterns.

Additionally, specific and targeted interventions were identified according to the complexity and particularity of clinical pictures. In the study by Sousa (2003), the

Live Exposure technique, with the aim of treating symptoms of agoraphobia. Cunha and Vandenberghe (2016) used the Matrix Diagram, a tool derived from Acceptance Therapy and Commitment (ACT), as a resource to promote greater awareness of standards behavioral and personal values. In the same study, the STOP technique was applied, a strategy self-regulation used to interrupt impulsive responses, helping the patient to act in a more deliberate way. In the case analyzed by Gauer (2023), modeling was used behavioral as a gradual reinforcement technique, encouraging progressive changes in the repertoire of the patient. Finally, in the study by Macedo *et al.* (2017), Recording techniques were used Dysfunctional Thoughts (DTH) and clinical scales for pain assessment, including the Visual Pain Scale Analogue (VAS) and the Widespread Pain Index (WPI), considering the concomitant presence of depressive symptoms and fibromyalgia.

Therapeutic tools used

Linehan (2015) emphasizes that the choice and application of therapeutic tools is fundamental to adapt treatment to the individual needs of patients, ensuring greater effectiveness in modifying maladaptive patterns. Analysis of the therapeutic tools used in cases clinical studies allows us to understand the diversity of approaches applied to the treatment of disorders emotional and behavioral.

In Sousa's study (2003), strategies such as the therapist's self-disclosure stood out, used with the aim of highlighting the emotional impacts of aggression in the therapeutic relationship, and the formalization of a verbal therapeutic contract, which aimed to commit the patient to the process. Based on this agreement, the client was instructed to analyze behavioral chains and implement new strategies to reduce aggressive behaviors, both directed at oneself regarding third parties. During the process, resistance was encountered, such as interruptions of sessions, low adherence and aggressive reactions, which required adaptations in the therapist's posture, including more systematic explanations of the interventions. We also sought to build a relationship stable and respectful therapy, with a focus on specific validation for interpersonal relationships. As As a result, the patient showed progress in tolerance and in managing her bonds over the course of the treatment.

In Gauer (2023), the therapist used engagement strategies in social activities such as therapeutic resource, encouraging the patient to participate in practices such as yoga, pole dancing and roller, with the aim of promoting greater social integration and a sense of belonging. At the same time, it was addressed a dysfunctional core belief — "I can't be who I am because I'm wrong" —

related to the fear of inadequacy, a characteristic frequently present in cases of borderline personality disorder. Behavioral alternatives were also explored in the face of impulsive and isolating patterns, promoting substitutions for more active activities adaptive. In addition, training was carried out to identify and name emotions, given the difficulty reported by the patient in this domain. As in the case of Sousa (2003), if the process of emotional validation based on the six levels proposed by Linehan (2015), including reading nonverbal signals and promoting a therapeutic relationship marked by equity and empathy.

In the case of Macedo *et al.* (2017), the need to confront resistance was verified therapeutic, especially intensified with the beginning of the preoperative process for surgery bariatric surgery. Adherence to treatment was promoted through flexible session formats, aiming for greater accessibility and patient engagement. Considering the diagnosis of fibromyalgia, an intervention was carried out aimed at the perception of chronic pain, with a psychosocial focus, seeking to promote acceptance and more functional management of pain in the context of monitoring psychological.

Therapeutic relationship

Linehan (1993) emphasizes that the consistency and continuity of the therapeutic bond are fundamental for promoting significant changes in patients with BPD. The literature also highlights the need to clearly establish the frequency of sessions, include ways of support between meetings and, when necessary, adopt multidisciplinary teams that expand the clinical resources and prevent discontinuities in treatment (Cavalheiro & Melo, 2016).

In the study by Sousa (2003), when interventions focused on problem solving were initiated problems, the patient began to report interpersonal difficulties related to the therapist, recognizing her as the only intimate relationship in his life. He reported fear of upsetting the therapist, including when he was offered the possibility of telephone contact between sessions. Such relationship evoked old feelings of loss. With the termination of treatment due to the change of country the therapist, the patient expressed understanding of the situation and demonstrated a willingness to give continuation of the process with another professional.

In Cunha and Vandenberghe (2016), three categories were identified that impacted the therapeutic relationship: (1) aggression and self-aggression, which generated tension in the therapist; (2) lack of engagement, manifested by resistance to interventions; and (3) polarization, characterized by dichotomous perceptions of the therapist and herself. These experiences aroused feelings of

frustration, failure and insecurity in the therapist, leading to the adoption of new strategies, such as self-disclosure and the construction of an integrated image of the therapeutic bond.

In Gauer's study (2023), the patient presented emotional detachment and hostility in session, leading the therapist to recognize countertransference reactions. Support in supervision allowed for the appropriate management of these emotions, maintaining empathy and continuity of service.

In Macedo *et al* (2017), the patient demonstrated strong resistance, often justifying absences with references to chronic pain. A pattern of ambivalence was noted, with worsening in the perception of pain in moments of therapeutic confrontation. Later, he recognized that his pain was related to emotional reactions and valued the importance of the therapeutic bond in its evolution.

Tavares *et al.* (2025), did not provide detailed information about the therapeutic relationship, merely indicating irregular adherence to TCD. This omission constitutes a significant gap, given that specialized literature points to the quality of the bond as one of the main predictors of success therapeutic in cases of BPD.

Maintenance after the end of the case study

Linehan (1993) highlights that continuity of treatment is fundamental for the consolidation of developed skills and prevention of relapses in patients with BPD, especially due to the emotional instability that characterizes the disorder.

In the studies by Sousa (2003) and Gauer (2023), it was observed that patients remained in psychotherapeutic follow-up after the formal closure of clinical reports. However, additional information was provided on therapeutic progress during this period, which limits the evaluation of long-term effectiveness.

In Cunha and Vandenberghe (2016), a follow-up session was carried out one month after the end of therapy. The patient demonstrated maintenance of therapeutic gains, ability to apply learned strategies to new challenges and understanding the possibility of relapses, which suggests effective internalization of the skills developed.

In the case of Tavares *et al.* (2025), there was no mention of the continuity of treatment after the closure of the study. Zanarini *et al.* (2006) point out that the lack of follow-up sustained may result in recurrence of symptoms and worsening of interpersonal difficulties.

In Macedo *et al.* (2017), the patient showed low adherence to treatment, abandoning it on several occasions. The discontinuation was attributed to resistance to the therapeutic approach and

emotional factors linked to fear of abandonment. The team opted to end the monitoring in the face of a lack of commitment, which reinforces the challenges of adherence faced by patients with BPD (Lieb *et* al., 2004).

These findings reinforce the importance of maintenance and therapeutic follow-up strategies, considering the chronic nature of BPD and the risks associated with premature discontinuation of treatment.

4. FINAL CONSIDERATIONS

This study had the general objective of analyzing the contributions of Behavioral Therapy Dialectical Therapy (DBT) in the treatment of Borderline Personality Disorder (BPD), considering its effectiveness in reducing symptoms and significantly improving patients' quality of life. To Therefore, several clinical and therapeutic aspects were investigated, including the effectiveness of DBT in reduction of symptoms of emotional instability, reduction of self-destructive behaviors, the development of emotional regulation skills, the improvement of interpersonal relationships and the reduction of comorbidities associated with BPD, such as anxiety and depression. Based on the data analyzed, it was possible to verify that TCD presents positive and consistent results in emotional stabilization and promoting more adaptive functioning for individuals diagnosed with BPD.

Regarding the main findings, it was observed that the majority of patients analyzed were female and had an age range between 27 and 34 years old that did not were found more in the critical phase, according to the literature, which points to a higher incidence of BPD in women and a more intense manifestation of symptoms in the young-adult phase between 18 and 25 years. Regarding the level of education, some participants had higher education, but in certain cases, faced difficulties in maintaining work due to the impacts of associated comorbidities. Regarding family history, it was found that, although there was no direct mention of psychological disorders in family members, the influence of invalidating environments and adverse childhood experiences played a significant role in the development of symptoms. With regarding treatment, the studies analyzed demonstrated variations in the duration and frequency of sessions, highlighting the importance of structuring and continuity of therapeutic care. Furthermore, it was found that drug intervention was a resource used in some cases, helping with emotional stabilization and managing depressive and anxiety symptoms.

The contributions of this study to Psychology are notable, as they reinforce the relevance of DBT as an evidence-based approach to the treatment of BPD. The research provides an understanding of effective therapeutic strategies for reducing symptoms and promoting more balanced functioning for individuals with BPD. In addition, findings contribute to clinical practice by emphasizing the importance of techniques such as validation emotional, training in interpersonal skills and tolerance to distress, allowing professionals in the field improve their interventions and expand therapeutic possibilities in management of the disorder.

During the realization of this study, some difficulties were encountered, particularly with regard to the scarcity of detailed information on the duration and structure of the treatments in the studies analyzed and of studies that collect data on other age groups, especially in the most critical phase in which Borderline personality disorder manifests itself. The lack of standardization in clinical reports also made comparisons between cases difficult, limiting the generalizability of the findings. In addition, the resistance of some patients to treatment and the high rate of therapeutic discontinuation were factors that impacted the achievement of more robust results.

When it comes to Dialectical Behavioral Therapy, criticism is made regarding the lack of independent studies, which are not linked to the creator of the method and which are relevant scientific, research that contemplates the isolated components of TCD, which help to study better its therapeutic effectiveness and compare it with other psychotherapies, such as therapies third wave of Cognitive Behavioral Psychology. One can also counterbalance between acceptance and change in the clinical practice of DBT, the fact that the therapy is highly protocol-based, structured and intensive, which can lead to a less patient-centered practice and, ultimately, the the fact that it is a therapy still in development and maturation.

Given the challenges identified, it is recommended that future research deepen the analysis of the effectiveness of Dialectical Behavior Therapy (DBT) in the long term, investigating with greater detail on treatment adherence and factors associated with its interruption. In addition, conducting studies with broader and more diverse samples in terms of age range, especially during critical periods of development, would allow for a greater understanding comprehensive analysis of the impact of DBT in different clinical and cultural contexts.

Additionally, it is critical that further research examine personality traits observable in childhood that may predispose to the development of Personality Disorder Borderline (BPD), since early identification of these factors allows for more effective interventions

effective. Finally, research into the role of family support in the treatment of BPD can provide essential subsidies for the formulation of more integrated interventions, favoring the therapeutic efficacy and maintenance of the results obtained.

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