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EFICACIA DE UN PROGRAMA DE INTERVENCIÓN BASADO EN LA TERAPIA DIALÉCTICO-CONDUCTUAL EN PACIENTES CON TRASTORNO LÍMITE DE LA PERSONALIDAD

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Resumen. El Trastorno Límite de la Personalidad (TLP) se considera un grave problema de salud mental, siendo una de las intervenciones para su tratamiento más eficaces la Terapia Dialéctico Conductual (DBT). El objetivo de este estudio es comprobar la eficacia de un programa de gestión emocional basado en la DBT para pacientes que tienen un diagnóstico de TLP, compuesto por cuatro bloques: mindfulness, eficacia interpersonal, regulación emocional y tolerancia al estrés. Se reclutó a 4 residentes del Centro Hospitalario Padre Menni de Santander, y se aplicó una evaluación pretratamiento y postratamiento, en formato individual, para medir las variables: ansiedad, depresión, funcionamiento global, regulación emocional, ideación suicida e impulsividad. Una vez realizada la valoración, se procedió con la intervención, compuesta por 14 sesiones con una frecuencia de 2 veces por semana, y duración de 45 minutos. Tras la aplicación se llevó a cabo el análisis de los resultados a través del estadístico ANOVA de medidas repetidas, aportando cambios estadísticamente significativos en la variable "regulación emocional" en la subescala supresión expresiva. Sin embargo, en base a los resultados obtenidos en la evaluación pre y postratamiento, si se ha producido un cambio clínicamente significativo, cumpliendo así de manera parcial los objetivos específicos. No obstante, se discutieron los resultados de la investigación planteando líneas a futuro en base a las limitaciones e implicaciones prácticas, contando con una muestra más significativa y adaptando el formato de la intervención.

Palabras clave: trastorno límite de la personalidad, terapia dialéctico-conductual, programa de gestión emocional, supresión expresiva.

EFFICACY OF AN INTERVENTION PROGRAMME BASED ON DIALECTICAL-BEHAVIOURAL THERAPY IN PATIENTS WITH BORDERLINE PERSONALITY DISORDER

Abstract. Borderline Personality Disorder (BPD) is considered a serious mental health problem, and one of the most effective interventions for its treatment is Dialectical Behavior Therapy (DBT). The aim of this study is to test the efficacy of an emotional management program based on DBT for patients with a diagnosis of BPD, composed of four blocks: mindfulness, interpersonal effectiveness, emotional regulation, and stress tolerance. Four residents of the Padre Menni Hospital Center in Santander were recruited, and a pre-treatment and post-treatment assessment was applied, in individual format, to measure the variables: anxiety, depression, global functioning, emotional regulation, suicidal ideation, and impulsivity. Once the assessment was completed, we proceeded with the intervention, consisting of 14 sessions with a frequency of twice a week, and a duration of 45 minutes. After the application, the analysis of the results was carried out through repeated measures ANOVA, providing statistically significant changes in the variable "emotional regulation" in the expressive suppression subscale. However, based on the results obtained in the pre- and post-treatment evaluation, there was a clinically significant change, thus partially fulfilling the specific objectives. Nevertheless, the results of the research were discussed, proposing future lines based on the limitations and practical implications, counting on a more significant sample and adapting the format of the intervention.

Keywords: borderline personality disorder, dialectical-behavioural therapy, emotional management program, expressive suppression.

Introduction

Borderline personality disorder (BPD) is a severe mental disorder, common in clinical practice, and characterized by high suicide rates, high rates of comorbidity, functional impairment, intensive treatment use, and high costs to society (Bender et al., 2001; Leichsenring, Leibing, Kruse, New & Leweke, 2011; Lieb, Zanarini, Schmahl, Linehan & Bohus, 2004; Oldham, 2006; Skodol et al., 2002; Skodol et al., 2005). According to the DSM-5 classification, the disorder is characterized by a pattern of instability in interpersonal relationships, self-image, and affect, as well as strong impulsivity (American Psychiatric Association, 2014). BPD is a pathology that has the reputation of being untreatable, and consequently people who suffer from it have to face a serious stigma, both in their social environment and among the professionals who care for them (Black et al., 2011; Gunderson, Herpertz, Skodol, Torgersen & Zanarini, 2018).

The first manifestations of BPD occur around puberty and early adulthood, although the age of diagnosis is usually between 19 and 24 years of age (Domènech, 2019). Consequently, treatment begins to be offered when the person is already in a late stage of the disorder, observing functional impairment and important complications at the iatrogenic level, which reduce the effectiveness and efficacy of the intervention (Bateman, Gunderson & Mulder, 2015; Gunderson et al., 2011).

Approximately 2% to 6% of the general population suffers from BPD, being more common than schizophrenia, bipolar disorder, and autism (Grant et al., 2008). In outpatients, it is estimated that 15% to 20% are diagnosed with BPD (Zimmerman, Rothschild & Chelminski, 2005), whereas, in inpatients, the rate can be as high as 25%

(Zanarini et al., 2004). According to the Clinical Practice Guideline on Borderline Personality Disorder, BPD is a disorder more frequent in women, with a ratio of 3 women diagnosed for every man (Álvarez et al., 2011; Domènech, 2019). Another characteristic of BPD is its high rates of suicide attempts, finding that between 60% and 85% of patients have attempted to end their lives on at least one occasion (Levy, McMain, Bateman & Clouthier, 2018; Pompili, Girardi, Ruberto & Tatarelli, 2005; Pos & Greenberg, 2007). Unfortunately, between 5% and 10% of them end up ending their lives (Goodman, Roiff, Oakes & Paris, 2011).

BPD is a disorder with high rates of comorbidity, most notably depression (at least 96% of patients with BPD have experienced a depressive episode once in their lifetime), anxiety (88%), PTSD (25-56%), substance use (23-84%), and BDD (14-53%) (Biskin & Paris, 2013; Golier et al., 2003; Grant et al., 2008; Hurt & Brown, 1984; McGlashan et al., 2000; Mueser et al., 1998; Oldham et al., 1995; Pope, Jonas, Hudson, Cohen & Gunderson, 1983; Shah & Zanarini, 2018; Yen et al., 2002; Zanarini et al., 1998; Zanarini, Gunderson & Frankenburg, 1989; Zimmerman & Mattia, 1999). High rates of comorbidity are a factor to be taken into account, as the symptomatology of comorbid disorders may overshadow BPD and thus hinder or delay its diagnosis.

The etiology of BPD is multifactorial, responding to the interaction between genetic and environmental factors. At the psychological level, some of the risk factors that can trigger the development of this disorder are childhood trauma, sexual or emotional abuse in childhood, an invalidating family environment, unfavourable parenting, object relations, insecure attachments or feelings of abandonment, and the capacity for symbolization-reflection (Keinänen, Johnson, Richards & Courtney, 2012). In addition, some extreme personality traits that predispose to BPD would be neuroticism, impulsivity, stimulation needs, and dependence (Zanarini et al., 2020). From the biological point of view, certain studies conducted with siblings and relatives in relation to BPD have shown that there may be an important genetic component in this disease, finding that 11.5% of people with BPD have a genetic predisposition (Calati, Gressier, Balestri & Serretti, 2013). And finally, at the social level, risk factors such as the predominance of the person's gender, social class, race, language, technology, culture, political economy, and institutional and professional structures and norms stand out (Brown, 1995). However, there are also protective factors in childhood, such as the number of emotionally sustaining relationships and competence in childhood (Borkum et al., 2017).

Chanen (2015) proposes some of the therapies that have been effective in BPD intervention, highlighting Cognitive Analytic Therapy (CAT), which is based on the classic cognitive-behavioral therapy (Chanen et al., 2009); Emotion Regulation Training (ERT) or STEPPS, which is a skills acquisition program (Blum et al., 2008); Beck's Cognitive Therapy (CBT), which is the classic therapy based on the identification of cognitive beliefs and subsequent modification (DeRubeis, Keefe & Beck, 2019); Young's Schema Focused Therapy (SFT), based on the identification and modification of maladaptive schemas; Mentalization-Based Therapy (MBT), psychodynamically oriented and based on attachment theory (Rossouw & Fonagy, 2012), and Dialectical Behavior Therapy (DBT), which is an intervention that combines individual therapy with skill acquisition (Mehlum et al., 2014).

In addition to these therapies, we find systems training for emotional prediction and problem solving (Blum, Pfohl, John, Monahan & Black, 2002), emotion regulation

group therapy (Gratz & Tull, 2011; Gregory et al., 2008; Gross et al., 2002), motive-oriented therapeutic relationship (Kramer, Guillory & Hancock, 2014), transference-focused psychotherapy (Clarkin, Yeomans & Kernberg, 2006; Comtois, Elwood, Holdcraft, Smith & Simpson, 2007; Comtois et al., 2003), and dynamic deconstructive psychotherapy (Gregory & Remen, 2008).

Dialectical behaviour therapy (DBT) is based on the theory of emotional dysregulation, postulated in 1993 by the author Marsha Linehan who argues that in people with BPD there is a decrease in the ability to regulate emotions, specifically the most intense emotions that are prolonged over time. During childhood, if these emotions are not adequately validated, they will trigger borderline personality behaviours in adulthood (Gunderson, Fruzzetti, Untuh & Choi-Kain, 2018; Linehan, 1993a). DBT emerges as a response to a group that was not benefiting from traditional Cognitive Behavioural Therapy (CBT): women with elevated suicidal ideation. The author integrates the concept of dialectics, recovering it from Greek philosophy, and the strategy of validation with the aim of improving the effectiveness of the therapy (Choi-Kain, Albert & Gunderson, 2016; Linehan, 1993a). Within the first clinical trials conducted for the treatment of self-injurious actions, it was seen that also patients met criteria for borderline personality disorder (BPD) (Leichsenring, Leibing, Kruse, New & Leweke, 2011).

The goal of DBT is to address BPD symptomatology by replacing maladaptive behaviours and integrating other more effective behaviours that can be used instead (Choi-Kain, Albert & Gunderson, 2016; May, Richardi & Barth, 2016). To this end, the therapy was divided into two groups, one focused primarily on skills training (acquisition and consolidation) and the other on current problem solving and motivational issues. The skills to be trained in each module are transcribed on paper and provided in the sessions. Traditionally, DBT consists of four parts: skills training group, individual therapy, telephone consultation, and therapist consultation team. The skills training group is aimed at equipping patients with tools to become more effective at certain behaviours that are common to BPD patients, such as instability of self, chaotic relationships, fear of abandonment, emotional liability, and impulsivity. These skills are learned through four modules: mindfulness, interpersonal effectiveness, emotional regulation, and stress tolerance. In turn, these four blocks are classified into skills: change skills, which encompass the interpersonal efficacy and emotional regulation block, and acceptance skills, which are mindfulness and stress tolerance (Linehan, 1993a; Linehan, 1993b; Linehan & Wilks, 2015; May, Richardi & Barth, 2016). Mindfulness is one of the central skills to work on in the course of therapy, being conceived of as "mindfulness," and requiring a concentration on the here and now, an awareness focused on the present moment combined with attitudes of acceptance and openness (Kabat-Zinn, 2009; Linehan, 2014). The person receiving the therapy will be trained in skills focused on training patients in what they should do at the time they practice mindfulness: observe, describe, and act ("what" skills), and those understood as the attitude that should be taken to perform this practice: not judging, focusing their attention and concentration on a particular moment, and being effective ("how" skills). The goal is for the person to be more effective in managing less desirable and painful emotions without trying to change or avoid them (Elices et al., 2016; Linehan et al., 2015). As for the block of interpersonal effectiveness, it will try to provide patients with the necessary skills to relate through three sections: achieving goals of assertiveness and limit setting, creating and maintaining relationships, and respecting oneself, being fair and faithful to one's beliefs and values. With all these tools, the aim is to teach people to

take into account the complexity of relationships and to cultivate the process of acceptance, flexibility, and change while obtaining improvements in collaboration and communication with other subjects (Lenz, Del Conte, Hollenbaugh & Callendar, 2016; Rathus & Miller, 2015). On the other hand, the aim of the stress tolerance module is to provide learning to patients in tolerating less desirable and dysregulated emotions. This module is also divided into two parts, the first being focused on learning skills for those crises that are short term, helping with distraction activities or activities that provide security to the person and allow them to self-soothe. The second section is more oriented to provide patients with tools at a conceptual level that focus on ideas of will and radical acceptance for more lasting situations over time such as grief (Lenz, Del Conte, Hollenbaugh & Callendar, 2016; Linehan et al., 2015). Finally, regarding the emotional regulation block, a set of behavioural and cognitive strategies are taught that help the reduction of unwanted emotions and increase those that are in demand. Emphasis is placed on the importance of the adaptive value of emotions when it comes to understanding them, through the skills of identifying and describing emotions, changing emotional responses, reducing the vulnerability of negative emotions, and managing more complicated emotions (Ekman & Davidson, 1994; Tooby & Cosmides, 1990).

Second, individual therapy focuses primarily on six areas: parasuicidal behaviours, behaviours that interfere with therapy, behaviours that interfere with quality of life, behavioural skills acquisition, post-traumatic stress behaviours, and self-esteem behaviours. The goal of this part of therapy, is to enhance and complement what is advanced in the group sessions (May, Richardi & Barth, 2016; Shearin & Linehan, 1993). On the other hand, telephone consultation allows the patient to contact the therapist for on-the-spot guidance. The calls are geared towards enabling the patient to effectively ask for help and apply the skills learned during the sessions, especially in times of crisis. Finally, the therapist consultation team is a weekly meeting in which all therapists who are providing DBT are grouped together. Sessions with patients who are highly suicidal can be stressful for therapists, so it is essential to maintain motivation and engagement to optimize therapy sessions (Linehan, 1993a; May, Richardi & Barth, 2016).

DBT is considered one of the first-choice treatments for patients at high suicidal risk and accumulating scientific evidence about its efficacy for the treatment of BPD, according to the latest reviews (Choi-Kain, Albert & Gunderson, 2016; Linehan et al., 2015; May, Richardi & Barth, 2016; Rios, 2020; Storebø et al., 2020). Borderline personality disorder is a severe and disabling condition, which has a high prevalence especially at the hospital level. Recently, new treatment approaches for this disorder are emerging, which open up a field of study regarding the efficacy of these approaches. DBT is supported by the scientific community; in fact, some authors claim that it is the only psychological treatment that to date has proven to be effective in the management of the symptomatology of people with BPD. Based on this evidence, the main objective of this study is proposed, which is to test the efficacy of an emotional management program based on DBT in hospitalized patients with BPD. In addition, the following specific objectives are proposed:

- Provide the subjects with the appropriate tools and concrete strategies to manage the symptoms that derive from their diagnosis.
- Learning to manage one's own behaviours, emotions, and thoughts that are related to difficulties in day to day life and come to produce discomfort.

- Put into practice the learning of adaptive and functional behaviours.

We worked from the hypothesis that the emotional management program, based on DBT, is effective in relation to the evaluated variables. That is to say, that the application of the designed program has a positive effect on the subjects of the study in relation to the improvement of the evaluated variables, which compose the symptomatology of BPD. As recent literature shows, it is an intervention specifically designed to treat borderline symptoms and the effectiveness of this treatment has been corroborated; therefore, this study deals with the verification of this effectiveness.

Method

Design

The research design is a single case with aggregated data since it is characterized by a continuous recording over time (sessions) of the behaviour of each individual subject, before, during, and after the withdrawal of the intervention, trying to estimate the size of the treatment effect. For this process a pre-evaluation is made, followed by the application of the intervention program, to finally carry out the post-evaluation; with all this we try to see the usefulness of the treatment applied and the changes experienced by the patient in relation to their behaviour. On the other hand, the methodology for this project is quantitative, as well as for the data analysis, the statistic used is ANOVA of repeated measures.

Participants

In this project, the sample consisted of 4 patients, one man and three women who live in the Padre Menni Hospital Centre (Santander, Cantabria). The recruitment method was discretionary, that is, probabilistic tools were not used. The only inclusion criterion for the selection of participants was that they had a diagnosis of borderline personality disorder (BPD).

Instruments

The variables to be taken into account in this research project are divided into three groups:

- Dependent variables: Anxiety, depression, suicidal ideation, emotional regulation, global functioning, and impulsivity.
- Independent variable: intervention.
- Covariate: age.

Emotional Regulation Questionnaire (ERQ).

The instrument evaluates, through 10 items, two types of strategies for the variable of emotional regulation: cognitive reappraisal (6 items) and expressive suppression (4 items). A Likert-type scale is used to answer the items, with response options ranging from 1 (strongly disagree) to 7 (strongly agree), an example of an item being, "When I want to increase my positive emotions, I change the topic I am thinking about." The questions in this scale are related to emotional life (how emotions are controlled and regulated), taking into account two main aspects, one being emotional

experience and the other emotional expression. (Balzarotti et al., 2010; Butler et al., 2007; Gillanders, Wild, Deighan & Gillanders, 2008; Gross & John, 2003; Ioannidis & Siegling, 2015; Verzeletti, Zammuner, Galli, Agnoli & Duregger, 2016; Westerlund & Santtila, 2018; Westerlund, Santtila & Antfolk, 2020). Cronbach's alpha for the suppression subscale was 0.75, while the reappraisal obtained an index of 0.79 (Cabello, Salguero, Fernández-Berrocal & Gross, 2013; González, Fernández-Berrocal, Ruiz-Aranda & Extremera, 2006).

Beck Depression Inventory (BDI-IA).

This test has the objective of measuring the variable "depression" in subjects (Sanz, 2013; Vázquez & Sanz, 1997); therefore, it consists of 21 items ordered from less to more severe, explaining in each one a certain depressive manifestation that is evaluated by the subject himself, selecting the phrase that best fits the situation currently presented (Beck, Rush, Shaw & Emery, 1979; Conde, Esteban & Useros, 1976; Conde & Franch, 1984). Four response alternatives are presented according to severity, being the score equal in all items, from 0 to 3, for example: 0- "I don't feel like a failure", 1- "I have had more failures than most people", 2- "When I look back all I see is one failure after another", 3- "I am a total failure as a person." The cut-off scores marking the severity of depression are 0-9 for minimal depression, 10-16 for mild depression, 17-29 for moderate depression, and 30-63 for severe depression (Beck & Steer, 1993; Beck, Steer & Carbin, 1988; Sanz, 2013). Regarding the internal consistency of the instrument, it presents a Cronbach's alpha of 0.83, highlighting a high reliability index of the scale (Sanz & Vázquez, 1998; Vázquez, Avia, Alonso & Fernández, 1989; Vázquez & Sanz, 1997).

Barratt Impulsivity Scale (BIS).

Questionnaire designed with the aim of assessing the tendency to impulsivity (measuring impulsivity in subjects) (Oquendo, Beca-García, Graver, Morales & Montalvan, 2001). The instrument is composed of 30 items divided into 3 subscales: cognitive impulsivity (8 items), motor impulsivity (10 items), and unplanned impulsivity (12 items). All items have four response options on a Likert-type scale ranging from 0 (rarely or never) to 4 (always or almost always). Some examples of the items are: "I say things without thinking about them," "I do things at the moment they occur to me," or "I buy things impulsively" (Guerrero Gallarday & Olano Yalta, 2017; Salvo & Castro, 2013). However, the median distribution in psychiatric patients, from the Spanish validation study of the scale, is used. For cognitive and motor impulsivity, the median is 9.5, for unplanned impulsivity it is 14, and for the scale as a whole it is 32.5 (Oquendo et al., 2001). In relation to its interpretation, there is no proposed cut-off point. Based on the internal consistency, they obtained values of 0.87 in Cronbach's alpha, which was a clear indicator of the high reliability that the test possesses (Martínez-Loredo, Fernández-Hermida, Fernández-Artamendi, Carballo & García-Rodríguez, 2015; Salvo & Castro, 2013; Stanford et al., 2009; Von Diemen, Szobot, Kessler & Pechansky, 2007).

State-Trait Anxiety Questionnaire (STAI).

This scale assesses state anxiety (transient emotional state) and trait anxiety (stable anxious tendency over time). Each subscale has a total of 20 items in a Likert-

type response system (from 0-not at all to 3-a lot). For example: "I am relaxed," 0- Not at all, 1-Somewhat, 2-Somewhat, 3-A lot. The maximum score in each of the two subscales is 60 (Castillo, Chacón & Díaz, 2016; Marteau & Bekker, 1992). For the trait anxiety factor, according to the Spanish adaptation of the STAI, an internal consistency value of 0.90 is estimated, and for the state anxiety subscale it is 0.94, reflecting a very good reliability index (Riquelme & Casal, 2011).

Global Assessment of Functioning Scale (GAF).

This test considers psychological, social, and occupational activity across a hypothetical health-illness continuum (APA, 2002). The test score is scored by the evaluator after an interview with the subject, which ranges from 0 (expectation of death) to 100 (satisfactory activity), taking into account the last twelve months with respect to the symptoms presented by the subject, the activities performed, and the social relationships on which the subject relies (Odriozola, Isasi & Arrillaga, 2003). In relation to the psychometric properties, it presents an internal consistency of 0.62, so it has an acceptable reliability (Hall, 1995).

Beck's Scale for Suicidal Ideation (SSI).

Instrument whose functionality is to quantify suicidal intentionality through the evaluation of self-destructive thoughts or ideas. The scale is made up of 21 items in the Spanish version, which consists of 3 response alternatives on a Likert-type scale. Likewise, this inventory can be completed by a psychologist based on the answers provided by the patient in a semi-structured interview (Beck, Kovacs & Weissman, 1979; Teruel, Martínez & León, 2014). An example of an item would be, "Reasons for the contemplated attempt": 0- Manipulate the environment, get attention, take revenge; 1- Combination of 0 and 2; 2- Escape, solve problems, end absolutely. Finally, the internal consistency is 0.89 for the general population being a very high reliability index (Beck, Kovacs & Weissman, 1979; Sánchez Teruel, García León & Muela Martínez, 2013).

Procedure

Prior to the start of the program, the project was evaluated by the Ethics Committee of the European University of the Atlantic, which approved the research. The sample was selected at the Padre Menni Hospital Center, being patients diagnosed with borderline personality disorder (BPD). As for the administration of the instruments, a pre- and post-assessment was carried out in sessions independent of the program. All participants were informed that they were going to be part of a study, the characteristics and objectives of the study were explained to them; then, they were informed that their participation was completely voluntary, anonymous, and that there would be complete confidentiality about the data obtained; furthermore, they were made to understand that since it was a voluntary act they could leave, although they had to sign an informed consent. The study consisted of an emotional management program based on dialectical behaviour therapy (DBT), consisting of 14 individual sessions plus 2 evaluation sessions. The intervention will be carried out twice a week, in sessions with

an approximate duration of 45 minutes, establishing as a dynamic for the sessions, the presentation of a theory related to the theme of emotional regulation combined with one or more exercises with the consequent objective of being completed by the patient for the next session. In addition, each session is preceded by a mindfulness exercise as well as ending with an exercise that consists of summarizing the session in a single sentence. The program is composed of 4 blocks, which are described below:

- Mindfulness skills: this module consists of the first four sessions in which participants are introduced to the concept of "mindfulness" through psychoeducation and experiential exercises as well as guided meditations.
- Interpersonal effectiveness: it covers sessions 5 to 8 in which the aim is to promote assertiveness skills and self-respect, clarifying at all times the priorities and objectives of the person in their relationships.
- Stress tolerance: in this module participants are provided with concrete tools and strategies to cope with situations that are difficult to manage and that generate high levels of stress through 3 sessions (sessions 9, 10, and 11).
- Emotional regulation: finally, the intervention closes with the emotional regulation module, which comprises the last 3 sessions. This part of the intervention focuses on teaching patients about emotions and how to manage them when they appear. It also focuses on how to analyze a situation in order to identify and interpret how certain thoughts and emotions are linked and whether or not the latter are adaptive.

The aim is to provide the patient with the necessary tools and skills to improve the performance of their daily life as well as with an increase in their quality of life.

Data analysis

In order to analyse and compare the results obtained, the SPSS statistical programme was used, which firstly allowed us to determine the characteristics of the sample based on the descriptive statistics mean and standard deviation. Secondly, and in order to compare the data obtained between the pre-treatment and post-treatment evaluation, the repeated measures ANOVA statistic was used, with an intrasubject factor. This statistic was used in order to check if there were significant differences in the application of the emotional management program in the measured variables.

It should be noted that, in this project, all the variables measured show an improvement if a lower score is obtained in the post-treatment compared to the pre-treatment, except in global performance, where the higher the direct score, the better the improvement.

Results

Table 1 shows the socio-demographic characteristics of the sample.

Table 1

Sociodemographic and clinical characteristics of the participants.

Features	Sample

Age	38.25 ± 6.131
Woman	3 (75%)
Man	1 (25%)
Primary Diagnosis	
Borderline Personality Disorder	4 (100%)
Other	0 (0%)
Clinical Variables	
Global Activity	56.25 ± 8.54
Suicidal Ideation	0.50 ± 1
Depression	13.75 ± 8.73
Anxiety-State	27.50 ± 15.17
Anxiety-Trait	25.75 ± 9.29
Impulsivity	49 ± 15.81
Cognitive Reassessment	5.04 ± 0.99
Cognitive Suppression	3.50 ± 0.87

Note. This table shows the values obtained after analysing the information acquired during the intervention process through descriptive statistics.

After the analysis of the scores obtained in the scales, through the study of variance, the results that determine the veracity of the hypothesis were obtained. These results show that, of the set of variables evaluated, it is emotional regulation in its subscale of expressive suppression in which a $p<0.05$ ($p=0.016$) is obtained. The results are detailed in table 2.

Table 2

Results of repeated measures ANOVA for clinical variables.

Variables [1]	**Pre**	**Post**	**F**	**GI**	**Sig.**	**ηp^2**
BDI-IA	12.25	13.75	0.586	1	0.524	0.227
STAI A.E	21.75	27.50	0.705	1	0.490	0.261
STAI A.R	27.75	25.75	5.472	1	0.144	0.732
BIS-11	49.00	49.00	0.01	1	0.929	0.005
ERQ R.C	5.4250	5.0400	1.062	1	0.411	0.347
ERQ S.E	3.5625	3.500	61.581	1	0.016 *	0.969
SSI	3.00	0.50	6.668	1	0.123	0.769
GAF	53.75	56.25	1.717	1	0.320	0.462

Note: This table shows the mean of the results obtained in the variables evaluated during the emotional management program for people with Borderline Personality Disorder (BPD). [1] Symptomatology assessed by instruments at the beginning and end of the intervention. *$p<0.05$

Pre: Pre-treatment, Post: Post-treatment, F: Value, Gl: Degrees of Freedom, Sig: Significance, ηp^2: Partial Eta Squared, GAF: Global Activity Assessment Scale

(GAAS), SSI: Scale for Suicidal Ideation, BDI-IA: Beck Depression Inventory, STAI: State-Trait Anxiety Questionnaire (A.E: State Anxiety and A.R: Trait Anxiety), BIS-11: Barratt Impulsivity Scale, and ERQ: Emotional Regulation Questionnaire (CR: Cognitive Reappraisal and ES: Expressive Suppression).

Discussion

The main objective of the study was to test the effectiveness of an emotional management program in patients diagnosed with BPD. This objective has been fulfilled since it has been possible to develop the program in its individual format as well as the achievement of the specific objectives. The participants have benefited in terms of strategies and tools. They have learned to manage emotions, thoughts, and behaviours that interfere in their daily lives, and they have been able to put this learning into practice through more adaptive and functional behaviours.

However, the hypothesis of the study cannot be accepted since there is not enough empirical data to show that the intervention is effective in the variables evaluated. However, it could be affirmed that the intervention is effective in relation to the variable "emotional regulation" in the subscale of expressive suppression, which raises certain conclusions. Expressive suppression is an emotional regulation strategy based on suppressing or modulating the emotional response. It is a response-focused strategy because it is used to regulate emotion after it has already been generated (Dryman & Heimberg, 2018; Gross & Jazaieri, 2014). This finding reaffirms existing evidence that DBT is effective in reducing emotional suppression (Dellanoce, 2019; Linehan, 1993). It is also important to mention not only the statistically significant changes but also those at the clinical level taking into account the covariate age. In the case of subject 1, it is worth mentioning that the direct score on the depression scale decreased 8 points from the pre-treatment assessment to the post-treatment assessment, indicating that the participant went from having "moderate" depression to "mild" depression. In the meta-analysis conducted by the Cochrane Collaboration in 2020, it was concluded that DBT was effective in reducing depressive symptomatology compared to no treatment. The same study revealed that DBT is more effective than treatment as usual in reducing impulsivity, which is consistent with the data obtained in subject 2, who shows a 14-point decrease in the direct score obtained on the impulsivity scale (Storebø et al., 2020). On the other hand, in subject 3, it can be seen how the score has decreased between pre-treatment and post-treatment assessment in the measure of the variable of emotional regulation in the subscale of cognitive reappraisal. In addition, in subject 4, it can be seen that the direct score on the suicidal ideation scale goes from 7 in the pre-treatment assessment to 0 in the post-treatment assessment, which is interpreted as clinically significant. Finally, in general and taking into account the mean of the pre-treatment and post-treatment measures of the 4 subjects, we can see a clinical improvement in the variables of anxiety (trait subscale), both subscales of emotional regulation, suicidal ideation, and global functioning. See table 2. These facts indicate that although the results of the study do not show a statistically significant change and therefore the hypothesis of the study cannot be approved, it can be affirmed that each subject has obtained a clinically observable benefit.

Regarding its application, it is worth mentioning the limitations of the research since the sample is considered unrepresentative, being N less than 30 subjects as well as the profile of the participants differed greatly, taking into account that each one has benefited to a greater extent from certain parts of the intervention, which is reflected in

the post-treatment evaluation scores. On the other hand, the variables may have been a conditioning factor in terms of the results since some of them depended more on factors external to the intervention than on the therapy itself. Likewise, in relation to the instruments, it would be interesting to review the assessment tests used, with the aim of applying more updated and appropriate versions for the purpose of the study. Another limiting factor would be that the program was carried out in a short space of time (8 weeks), it can be deduced that it would probably have been more effective if it had been carried out in a larger number of sessions, being the duration longer than 2 months and with greater continuity throughout the weeks, that is to say, with a greater number of weekly hours without exceeding the limits of saturation of the individual. Another point to highlight would be the follow-up of the daily practice since most of the times the majority of individuals did not bring completed proposed activities, which could be a limiting factor when it comes to obtaining improvements in the post-tests. On the other hand, a key limitation to highlight is the lack of originality of the intervention program applied since it is very faithful to the original structure of DBT proposed by Marcha Linehan. Finally, it is necessary to refer to the level of activation received by each subject depending on the unit in which they are hospitalized as well as the personal situation they have had throughout the treatment process, which undoubtedly may have influenced the results in the same way as the situation experienced during the pandemic by the COVID-19.

As for the practical implications of the research, they are considered very rich at the clinical level, mainly in relation to the profile of the participants since it allows a greater use of the treatment. In spite of the fact that the statistical results do not reveal an improvement, the daily functioning of the patients changed and they were able to take advantage of the resources that were offered to them through the program which could be interpreted as a therapeutic success.

Consequently, as lines of future research, firstly, it is necessary to highlight the importance of carrying out this same study with a significant sample size while carrying out the program in an affordable time frame, where it would be possible to have an extensive, complete, and necessary impact on the 4 blocks that make it up as well as with a positive weekly continuity; in addition, it could be considered that the treatment format would not only be individual but also in a group so that the members of the study can learn from each other. In fact, a revision of the intervention program used could be proposed, trying to make it less theoretical and more practical, making the sessions more dynamic and giving priority to the establishment of the therapist-patient bond, where a space is created in which emotional expression is encouraged as well as feedback from the patient in relation to how he/she integrates the skills acquired in therapy and the use he/she makes of them in his/her daily life. Therefore, once the results obtained in this study have been analysed, it would be important to have a greater impact when intervening in the variables that have a score that is too far from what is considered a significant change ($p<0.05$). Finally, apply the program in other patients who do not necessarily have a diagnosis of BPD, since it has been shown that DBT can be effective with other types of pathologies.

Conclusion

DBT has demonstrated its efficacy on multiple occasions and has been assessed by the Cochrane Collaboration as the most effective therapy in the treatment of BPD. The aim of this study is to test the efficacy of a DBT-based program in patients with BPD, and although the results show statistically significant conclusions in a single

variable, there are clinical improvements in other variables in the subjects of the research. This refers to emotional regulation, more specifically in the subscale expressive suppression in which there has been a statistically and clinically significant change. In the rest of the variables no improvement has been found, although it has been observed that all patients have benefited from each of the modules of the intervention, highlighting the skills of interpersonal efficacy and mindfulness. This means that although there has not been a significant change at a statistical level, the intervention has been effective at a clinical level where the participants have improved their social functioning and have a greater range of resources through which they can better manage their emotions, self-regulate, and curb those impulsive behaviours that are harmful to themselves. However, it is noted that further research is needed, taking into account the limitations of the present study and providing new lines of study that benefit both the subjects themselves and psychology as a science.

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